

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01725

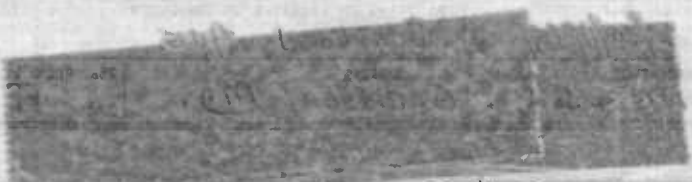
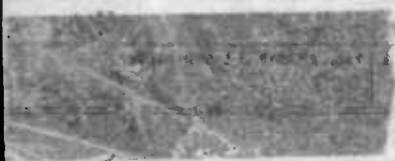
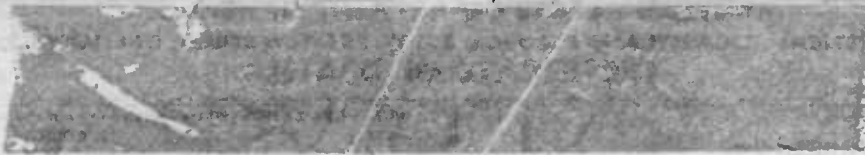
01722

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1025 FLAGTREE LANE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>1025 FLAGTREE LANE</u>			
3. NAME OF DECEASED (Type or print) <u>ROBERT ERWIN ABRAMSON</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>8</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>AUG. 21, 1911</u>		9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARRY ABRAMSON</u>			14. MOTHER'S MAIDEN NAME <u>ANNA</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-4278</u>		17. INFORMANT <u>FRANCES ABRAMSON - SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1964</u> to <u>Feb 8, 1967</u>, that (I) (we) last saw the deceased alive on <u>Feb 8, 1967</u>, and that death occurred at <u>2A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Manuel Levin</u>				22b. DATE SIGNED <u>2/8/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>				22d. ADDRESS <u>4818 REISTERSTOWN RD BALTO MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 10 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>AUG</u>			
23d. LOCATION (City, town or county) <u>BALTIMORE</u>		23e. (State) <u>MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>SYLVAN S. LEVIN & SON</u>				25a. REC'D BY REGISTRAR <u>FEB 10 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>GARRISON MD</u>				25c. ADDRESS <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01726

CERTIFICATE OF DEATH

01723

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b Reisterstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 100 Westminster Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 100 Westminster Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle H. Last Albright		4. DATE OF DEATH Month February Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1893
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Hoover		14. MOTHER'S MAIDEN NAME Anna Ragsadle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss. T. May Albright		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Insufficiency - DUE TO Coronary Thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 days years years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1- , 19 60 , to 2-13- , 19 67 , that (I) (we) last saw the deceased alive on 2-13- , 19 67 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE James G. Saffell		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) James G. Saffell M.D.		22d. ADDRESS Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/16/67	
23c. NAME OF CEMETERY OR CREMATORY Black Rock		23d. LOCATION (City or Town) (County) (State) Butler Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Reisterstown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 16 1967			

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MINISTRE DE LA SÉCURITÉ

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FEB 17 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01727

CERTIFICATE OF DEATH

01724

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 59 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1011 West Lanvale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THEODORE - - - ALEXANDER				4. DATE OF DEATH Month Day Year FEBRUARY 22 19 67			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 23, 1900	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CHARLOTTE, N.C.	
13. FATHER'S NAME THOMAS ALEXANDER				14. MOTHER'S MAIDEN NAME LENA MN: UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 212 16 94 26		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BROCHOGENIC CARCINOMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERLUPTED						INTERVAL BETWEEN ONSET DAYS MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 14 (this hospital) attended the deceased from DEC. 26 , 19 66 , to FEB. 22 , 19 67 that 1 (we) lost the deceased alive on FEB. 22 , 19 67 , and that death occurred at 1145 PM , from causes and on the date stated above.							
22a. SIGNATURE Sheldon E. Kaimutz				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/23/67	
22c. PHYSICIAN'S NAME (Type) SHELDON E. KAIMUTZ, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/27/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Charles A Rice		25a. REC'D BY REGISTRAR 661		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS RICE FUNERAL HOME W. BARRE ST. BALTIMORE, MD	

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RECEIVED AT DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
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Item 9 Film G506 3/1/67									
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
c. LENGTH OF STAY IN 1b 1 year					d. STREET ADDRESS 1245 E. Belvedere Ave. 21212				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ridge Way Manor Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GERTRUDE H. ALLEN					4. DATE OF DEATH Month February Day 20 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 13, 1891		9. AGE (In years last birthday) 76 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) Baltimore City			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Thomas					14. MOTHER'S MAIDEN NAME Sauter				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-14-3545		17. INFORMANT James F. Allen			Address 1245 E. Belvedere Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } b) c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 1960 , to 20 20 , 19 67 , that (I) (we) last saw the deceased alive on 19 Feb 19 67 , and that death occurred at 4:45 M, from the causes and on the date stated above. 22a. SIGNATURE William Goodman, MD M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Dr. William Goodman 22d. ADDRESS 1334 Sulphur Spring Road 21227 22b. DATE SIGNED 1967 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-23-67		23c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cemetery		23d. LOCATION (City, town or county) (State) Long Green Baltimore Co.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc.				ADDRESS 1217 St. Paul Street		25a. REC'D BY REGISTRAR FEB 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judo	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01726

01729

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EastPoint		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, # 21224, 304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7917 E. Baltimore St., # 21224		d. STREET ADDRESS 2608 Foster Ave.	
3. NAME OF DECEASED (Type or print) THOMAS FRANCIS ALLEN, Jr.		4. DATE OF DEATH Month February Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1922
9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Bermuda Shipp. Co. New York, N.Y.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Allen, Sr.		14. MOTHER'S MAIDEN NAME Rose Garrity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. II 720-10-7279	
17. INFORMANT Ann Henric		Address 90 Arcadia Rd. Allendale, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theodore C. Patterson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Theodore C. Patterson		DATE SIGNED 2/3/67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-7-67	22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery, Long Island, N.Y.	22d. LOCATION (City, town, or county) (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jailer		ADDRESS 6224 Eastern Ave. Balto., 21224, Md.	
24a. REC'D BY REGISTRAR FEB 7 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY-LEAFY STATEMENT OF HEALTH - BANGMORE IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01128

NAME		THOMAS, J. J.	
AGE		35	
SEX		Male	
RACE		White	
BIRTH DATE		1900-10-10	
BIRTH PLACE		New York, N.Y.	
RESIDENCE		New York, N.Y.	
OCCUPATION		None	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE		[Signature]	
DATE		1935-10-15	
PLACE		New York, N.Y.	
MEDICAL EXAMINER		J. J. Thomas	
HOSPITAL		None	
CORONER		None	
BURIAL PLACE		None	
FAMILY HISTORY		None	
SOCIAL HISTORY		None	
PHYSICAL EXAMINATION		None	
LABORATORY EXAMINATION		None	
X-RAY EXAMINATION		None	
AUTOPSY		None	
OTHER		None	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01730

01727

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
56 <u>Greater Baltimore Medical Center</u>		<u>2515 Hillford Drive</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Dorothy</u> Middle <u>Alberta</u> Last <u>Allmond</u>		Month <u>2</u> - Day <u>12</u> Year <u>1967</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>10-15 '99</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>			
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Wm. J. Ritter</u>		<u>Bartz, Wilhelmina</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>212055205 D</u>	
17. INFORMANT		Address	
<u>Mr. Floyd M. Allmond</u>		<u>4322 Ridge Rd. #36</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of ovary.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 23, 1967</u> , to <u>Feb. 12, 1967</u> that (I) (we) last saw the deceased alive on <u>Feb. 12, 1967</u> , and that death occurred at <u>9:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<u>Robert W. Smith</u> M.D.		<u>2-12-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
<u>Robert W. Smith</u>		<u>Greater Balto. Med Cen.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>2/16/67</u>	<u>Parkwood Cemetery</u>	<u>Baltimore Co., Maryland</u>
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR	
<u>Leonard J. Ruck Inc. 5305 Harford Rd. #14</u>		<u>DATE FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE	
		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Index

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01731					01728						
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u> c. LENGTH OF STAY IN 1b <u>30-4</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5002 BELAIR ROAD</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>G. B. M. C.</u>					d. STREET ADDRESS <u>5002 BELAIR ROAD</u>						
3. NAME OF DECEASED (Type or print) <u>CHARLES B Apple</u>			First Middle Last		4. DATE OF DEATH <u>2 5 19 67</u>		Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-1-1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Art-Litho Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>CHARLES Lee Apple</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Kirby</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>212-01-2524</u>				16. SOCIAL SECURITY NO. <u>212-01-2524</u>		17. INFORMANT <u>Gloria E. Apple</u>		Address <u>-5002 Belair Road-21206</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>163X</u> DUE TO <u>Cancer of Lung St.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>metastasis.</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1st, 1967</u> , to <u>Feb 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-8 1967</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edmundo KARRANDEGA</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-5-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>EDMUNDO KARRANDEGA</u>				22d. ADDRESS <u>G. B. M. C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>John C. Miller Inc.</u>				ADDRESS <u>6415 Belair Rd.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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G.A.M.C.

Male CAN

Lithographer

Charles Lee Apple

Charles B

X

Apple

4-1-1902 64

Baltimore Md

Kirby

5002 BELAIR ROAD

U.S.A.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01732

CERTIFICATE OF DEATH

01729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u>		d. STREET ADDRESS <u>2915 Conroy Court</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Blanche Winifred Arnold</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/03</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saleslady</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARION, S. D</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Wendelin</u>		14. MOTHER'S MAIDEN NAME <u>Myer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>526-05-6853</u>	
17. INFORMANT <u>Patient's Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastrointestinal hemorrhage</u> 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hemorrhagic cecitis with infarction</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>67</u> , to <u>2/9</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/9</u> 19 <u>67</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Juan L. Roque</u>		22b. DATE SIGNED <u>2/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>		22d. ADDRESS <u>68M c. Balto 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-11-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn L. Home</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>	
ADDRESS <u>7401 Belair Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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1992

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01733

CERTIFICATE OF DEATH

01730

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>23 Dutton Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>23 Dutton Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Frank Arnold, Sr.</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1897</u>		9. AGE (In years lost birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Frank</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>215-12-8106</u>		17. INFORMANT <u>Mrs. Frank Arnold</u> Address <u>23 Dutton Ave. - 21228</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis of Coronary Vessels</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>59</u> , to <u>2/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.									
22a. SIGNATURE <u>Cliff Ratcliff</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Cliff Ratcliff</u>				22d. ADDRESS <u>4605 Edmondson Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Witzke F.D.-4101 Edmondson Ave.</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>FEB 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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1951, 1952, 1953

1951-1952

1951-1952

FOR STATE
HEALTH DEPT.

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MD. STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01731

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore County General Hospital		d. STREET ADDRESS 5 Rolling View Drive	
3. NAME OF DECEASED (Type or print) Richard S. Ash		4. DATE OF DEATH Feb. 3, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reproduction Mgr.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Richard H. Ash		14. MOTHER'S MAIDEN NAME Bertha S. Cline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-05-8322	
17. INFORMANT Mrs. Alice M. Ash-5 Rolling View Drive		Address Eldersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head. 976X DUE TO (b) Mental Depression Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 min. 6 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased took a 30-30 martin rifle & shot himself.	
20c. TIME OF INJURY Hour e.m. 8:30 Month, Day, Year Feb. 3 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Sykesville Carroll Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Reisterstown Md.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/6/67	22c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Cemetery	22d. LOCATION (City, town, or country) (State) Liberty Rd. Md.
23. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, Md.		24e. REC'D BY REGISTRAR FEB 7 1967	
		24b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01735					01732				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY BALTIMORE					a. STATE MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON 21204					b. COUNTY BALTIMORE				
c. LENGTH OF STAY IN 1b 1 day					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON, BALTO, MD. 21204				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTO. MEDICAL CENTER					d. STREET ADDRESS 914 JULANNEY VALLEY RD.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last WILLIAM MAY BARNHARD.					Month Day Year FEB 4 1967				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-25-95		9. AGE (in years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEMAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WOODBIDGE, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
13. FATHER'S NAME ROBERT GILLIS					14. MOTHER'S MAIDEN NAME DONNOLLY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. —				
17. INFORMANT HAROLD BARNHARD.					Address Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5811 Laguerre's carcinoma of liver DUE TO (b) Ca of breast and Ca of mouth DUE TO (c) with extensive metastases in lung and portacaval system PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probably metastasis to brain 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. AGONY WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from JAN 1967 to Feb 4 1967 that (I) (we) last saw the deceased alive on Feb 4 1967 and that death occurred at 2:30 PM from the causes and on the date stated above.									
22a. SIGNATURE S. e. chang									
22b. DATE SIGNED Feb 4 67									
22c. PHYSICIAN'S NAME (Type) Seock C CHANG									
22d. ADDRESS G B M C									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF Feb. 7, 1967									
23c. NAME OF CEMETERY OR CREMATORY Cloverleaf Park Cemetery									
23d. LOCATION (City, town or county) (State) Woodbridge, New Jersey									
24. FUNERAL DIRECTOR 1050 York Road									
25a. REC'D BY REGISTRAR Wm. Cook-Brooks Towson, Towson, Maryland 21204									
25b. REGISTRAR'S SIGNATURE Charles Judge									

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01736

CERTIFICATE OF DEATH

01733

1. PLACE OF DEATH a. COUNTY: Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines Catonsville		d. STREET ADDRESS 2648 Maryland Avenue 21206	
3. NAME OF DECEASED (Type or print) First John Middle L Last Barr		4. DATE OF DEATH Month February Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1882
9. AGE (In years lost birthday) 84 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Refriger Engineer	
11. BIRTHPLACE (County & State, or foreign country) Washington Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barr		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234-05-0031A	
17. INFORMANT Mr Preston Barr		Address 5904 Greenhill Avenue 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-24, 1966 , to 2-16, 1967 , that (I) (we) last saw the deceased alive on 2-14, 1967 , and that death occurred at 10 P. M, from causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher, Sr.		22b. DATE SIGNED 2-17-67	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, Sr.		22d. ADDRESS 6209 Frederick Dr. Balt. 21228, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-20-1967	23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Waynesboro Penna.
24. FUNERAL DIRECTOR Lassahn Funeral Home		25. REC'D BY REGISTRAR Charles Judge	
25a. ADDRESS 5401 Belair Road		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 20 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01433

CERTIFICATE OF DEATH

01433

Name of deceased		John Doe	
Age		45	
Sex		Male	
Race		White	
Date of death		1965-10-15	
Place of death		Home, 123 Main St, Springfield, Ill.	
Cause of death		Heart disease	
Manner of death		Natural	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		1965-10-20	
Place of registration		City of Springfield, Ill.	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01737

CERTIFICATE OF DEATH

01734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 55 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 2446 W. Baltimore Street	
3. NAME OF DECEASED (Type or print) First JOHN Middle ROLAND Last BASS		4. DATE OF DEATH Month FEBRUARY Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/15
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
11. BIRTHPLACE (County & State, or foreign country) Norfolk, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN R. BASS		14. MOTHER'S MAIDEN NAME ANNIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 577-18-46-62	
17. INFORMANT Clinical Records, VAH, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NEPHROSCLEROSIS AND UREMIA. DIABETIS MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that He (this hospital) attended the deceased from Jan. 3 , 19 67 , to Feb. 26 , 19 67 , that He (we) last saw the deceased alive on Feb. 26 , 19 67 , and that death occurred at 6:40 AM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter Jovan</i>		22b. DATE SIGNED 2/26/67	
22c. PHYSICIAN'S NAME (Type) PETER JOVAN, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-2-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR <i>Kelson Funeral Home</i> Kelson Funeral Home		25a. REC'D BY REGISTRAR MAR 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01738

01735

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>				d. STREET ADDRESS <u>HOPKINS Apartments</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Florence</u> Last <u>Bayless</u>				4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 14, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baithers & Williams</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John T. Bayless</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Burke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-54-61281</u>		17. INFORMANT <u>Records of Md. Masonic Homes, Cockeysville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200 1 Arteriosclerotic heart disease</u> DUE TO <u>2 Diabetes Mellitus</u> DUE TO <u>3 Broncho pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>65</u> to <u>Feb 13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Tamshid Hamed MD</u>				22b. DATE SIGNED <u>Feb 13, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>TAMSHID HAMED MD</u>	
22d. ADDRESS <u>Masonic Home</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson,</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01332

01739

CERTIFICATE OF DEATH

01736

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Baltimore 21213 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21213 d. STREET ADDRESS 1941 N. Patterson Park Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle M. Last Beste 4. DATE OF DEATH Month February Day 16 Year 1967		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH September 18, 1893 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Thatcher Bell 14. MOTHER'S MAIDEN NAME Laura Chilcote	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-12-7757 17. INFORMANT Mrs. Mary Nelson-3201 Glendale Ave.-21234 Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory arrest DUE TO (b) Cerebral hemorrhage DUE TO (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/7/1967 , to 2/16/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/16/1967 , and that death occurred at 8:25 M. from causes and on the date stated above.	
22a. SIGNATURE Jaime Singzon 22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D. 22d. ADDRESS 7620 York Rd., Towson, Md. 21204		22b. DATE SIGNED February 16, 1967 A. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-20-67 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland		24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Road-21206 25a. REC'D BY REGISTRAR FEB 23 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01326

02310

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01740

CERTIFICATE OF DEATH

01737

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecilia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 mo. 16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u>				d. STREET ADDRESS <u>R. D. #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Franklin Bines Sr.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 7 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RA. RR.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Bines</u>				14. MOTHER'S MAIDEN NAME <u>SARAH Boyd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>717-07-5522</u>		17. INFORMANT Address <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 715X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decubitus Ulcer</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 22, 1966</u> , to <u>Feb. 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 9, 1967</u> , and that death occurred at <u>5:40 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ferdinand Massari</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ferdinand Massari</u>				22d. ADDRESS <u>Spring Grove State Hospital Baltimore - Md. 21228</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-12-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Principis Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Perryville, Md.</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01741

CERTIFICATE OF DEATH

01738

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr4mth6dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olga Middle Binkley Last Binkley		4. DATE OF DEATH Month February Day 11 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1886
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY housewife	
12. BIRTHPLACE (County & State, or foreign country) New York		13. CITIZEN OF WHAT COUNTRY? U. S.	
14. FATHER'S NAME John Henry Olyann		15. MOTHER'S MAIDEN NAME Minnie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. 218-03-5070D	
18. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that no (this hospital) attended the deceased from Oct. 5, 1964 to Feb. 11, 1967 , that no (we) last saw the deceased alive on Feb. 11, 1967 , and that death occurred at 8:30 M, from causes and on the date stated above.			
22a. SIGNATURE Narciso W. Carmona M.D.		22b. DATE SIGNED 2-11-67	
22c. PHYSICIAN'S NAME (Type) Narciso W. Carmona		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2/23/67	23c. NAME OF CEMETERY OR CREMATORY Louisa PK Cem	23d. LOCATION (City or Town) (County) (State) BALTO MD
24. FUNERAL DIRECTOR E. S. Mac Nabb Catonsville 28 MD		25. REC'D BY REGISTRAR FEB 24 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

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FOR STATE
HEALTH DEPT.

01742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01739

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN TB Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital				d. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print) Stewart M. BLAIR		4. DATE OF DEATH Month February		Day 12,	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 27, 1906		9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR Months 12,	
11. BIRTHPLACE (State or foreign country) N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lee BLAIR	
14. MOTHER'S MAIDEN NAME EMMA Matheson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Mrs. Mary Blair - Rt. 2 Finksburg, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary emboli complicating fracture of left patella 8160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Driver of truck which struck another truck in rear 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fractured left knee cap on job 20c. TIME OF INJURY Month, Day, Year 9:30 AM 1-10 1967 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) work Highway 20f. (City or town) (County) (State) Baltimore Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED February 13, 1967		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 2-16-67		23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll Co. Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25. REC'D BY REGISTRAR Feb 20 1967		26. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

<div>10</div> <div>1</div> <div>M</div> <div>01743</div> <div>01740</div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 19 years						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14 Morrisway Road						d. STREET ADDRESS 14 Morrisway Road					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First			Middle			Last		
			CHARLES			HENRY			BOECKER		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 27, 1923		43 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canvas Salesman				10b. KIND OF BUSINESS OR INDUSTRY F.M. Stevenson				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				14. MOTHER'S MAIDEN NAME Regina A. Dumler							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-18-9273				17. INFORMANT Mrs. Doris L. Boecker, 14 Morrisway Rd. Owings Mills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cerebral Thrombosis											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Arteriosclerotic C.V. Disease											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1953 to February 6, 1967 that (I) (we) last saw the deceased alive on Dec. 1, 1966, and that death occurred at 10 AM, from the causes and on the date stated above.											
22a. SIGNATURE Martin E. Strobel											
22b. DATE SIGNED 2-8-67											
22c. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.											
22d. ADDRESS 48 Main St. Reisterstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
Burial			2/9/67			Evergreen Mem. Gardens			Finksburg, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE H. J. Eckhardt						ADDRESS Owings Mills, Md.			25a. REC'D BY REGISTRAR DATE FEB 10 1967		
									25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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01546

Source: *Author's calculations*.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01744

CERTIFICATE OF DEATH

01741

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIA Middle C. Last BOGNANNI		4. DATE OF DEATH Month Feb. Day 7, Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/82
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 5 Days 4 Hours 1 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coat Felter		12. KIND OF BUSINESS OR INDUSTRY Dvorak Bros.	
13. BIRTHPLACE (County & State, or foreign country) Italy		14. CITIZEN OF WHAT COUNTRY? Italy	
15. FATHER'S NAME Bayli		16. MOTHER'S MAIDEN NAME unknown	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. 216-02-2907	
19. INFORMANT Josephine Udes, dght, above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio-Vascular Disease DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Disease (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26/66 to 2/7/67 , that (I) (we) last saw the deceased alive on 2/9/67 , and that death occurred at 1230 AM from causes and on the date stated above.		22b. DATE SIGNED 2/8/67	
22a. SIGNATURE Dr. W. E. McGrath		22c. PHYSICIAN'S NAME (Type) Dr. W. E. McGrath	
22d. ADDRESS 1903 Frederick Road		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25a. REC'D BY REGISTRAR FEB 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 3331 Brehms Lane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01741

01741

Baltimore

Baltimore

Charmville

Summit Nursing Home

4531 Melair Road

Maria

ROBERTA

Feb. 7, 1967

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Wife

X. SIVERS

of

Wife

UNION BRO. Maria

ITAN

210-2-2807 - Josephine Urban, Capt., above

4110 2nd Ave. N. - above

6103 E. 1st St.

1313 Frederick Road

Dr. W. W. Mott

1011 Northwood Company, Baltimore, Md.

Continental General Corp., Inc.
3331 Eastern Ave.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01745

CERTIFICATE OF DEATH

01742

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 292 Bloomsbury Ave. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 292 Bloomsbury Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 292 Bloomsbury Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William O. Bomberger		4. DATE OF DEATH Month Day Year Feb. 26, 1967	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1900
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Accountant		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - Arthur Bomberger		14. MOTHER'S MAIDEN NAME Late - Frances ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clara Bomberger 292 Bloomsbury Ave. - Apt. B-9		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARDIAC ARREST. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMATOSIS (c) CARCINOMA, LUNG.			INTERVAL BETWEEN ONSET AND DEATH 4 MO. 15 MO.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-18 , 1967 , to 2-26 , 1967 , that (I) (we) last saw the deceased alive on 2-10 , 1967 and that death occurred at 11:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Peter V. B. Thorpe		22b. DATE SIGNED 2-27-67	
22c. PHYSICIAN'S NAME (Type) Peter V. B. Thorpe, M. D.		22d. ADDRESS 409 Columbia Pike-Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-2-67	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25. REC'D BY REGISTRAR FEB 28 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G 385 2/8/67 jml

CERTIFICATE OF DEATH

01746

01743

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>BALTIMORE</u>		<u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<u>BALTIMORE COUNTY GEN. HOSP.</u>		<u>615 N. KENWOOD AVE</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last <u>AUGUSTA B. BOOTH</u>		Month Day Year <u>2-2-1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/7/83</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>HOUSEWIFE</u>		<u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>BALTIMORE</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>JOHN NEUBERT</u>		<u>SOPHIA GARDNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
		<u>CHART</u>	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA & POSSIBLE CVA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LEUKEMIA, Lymphatic Chronic</u> DUE TO (c) <u>THROMBOCYTOPENIA</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> , 19 <u>67</u> , to <u>2/2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/2</u> 19 <u>67</u> , and that death occurred at <u>6:55</u> AM, from causes and on the date stated above.		
22a. SIGNATURE <u>Mariano A. Plentino</u>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/2/67</u>
22c. PHYSICIAN'S NAME (Type) <u>MARIANO A. PLENTINO</u>	22d. ADDRESS <u>1537 SIMMONDS AVE. BALT, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER Cem.</u>
23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Hartley Miller Mountford + Jefferson St.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01747					01744					
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN lb 3 yrs. 11 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 30-4					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice					d. STREET ADDRESS Hillenwood(2019) Road 14			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Henry R. Borig					4. DATE OF DEATH Feb. 14 1967					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/1887		9. AGE (In years last birthday) 79		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Trans. Operator					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Borig					14. MOTHER'S MAIDEN NAME Mary Sterner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO. 215-09-3775		17. INFORMANT Records Stella Maris Hospice					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Respiratory Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO (c) Generalized Ca								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from April 10, 1967 to 2-14, 1967, that (I) (we) last saw the deceased alive on 2-12-1967, and that death occurred at 3:28 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Robert J. Mahon, M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.					22d. ADDRESS 204 E. Joppa Road					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Memorial Gardens		23d. LOCATION (City, town or county) Baltimore Co.,		23e. (State) Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce-4001 Ritchie Hgwy., Baltimore					25a. REC'D BY REGISTRAR DATE FEB 17 1967		25b. REGISTRAR'S SIGNATURE John J. Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01748

CERTIFICATE OF DEATH

01745

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>3418 Ripple Road #7</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATHILDE BORRIS</u>		4. DATE OF DEATH Month Day Year <u>February 10, 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Oppenheimer</u>		14. MOTHER'S MAIDEN NAME <u>Rosa ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. Gunther Borris, 3418 Ripple Road #7</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4201</u> DUE TO <u>Coronary Thrombosis - General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerosis</u> DUE TO <u>(Age)</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Abdominal Tumor c. Obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>25 years</u> to <u>2110</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2110</u> 19 <u>67</u> , and that death occurred at <u>6 p.m.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Kurt Levy, M.D.</u>		22b. DATE SIGNED <u>2/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Kurt Levy</u>		22d. ADDRESS <u>3103 North Charles Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cheverre Ahavas Chessed</u>	23d. LOCATION (City or Town) (County) (State) <u>Randallstown, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01745

MINUTE OF MEETING

01745

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FOR STATE
HEALTH DEPT.

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01746

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 11 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2522 McComas Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Bosley Last Bosley		4. DATE OF DEATH Month February Day 2 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/84
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Pfort		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-54-1878	
17. INFORMANT (Husband) Abram W. Bosley, 2522 McComas Ave. Dundalk,		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B. Davis		M.D. M.D.	
EXAMINER'S NAME (Type)		22. DATE SIGNED 2/3/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR FEB 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Figure 2

10. *Impatiens*

5. *Journal of the American Medical Association*, 1990; 263: 1033-1036.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 385 2-14-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01747

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A.</u> Last <u>Bowerman</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>6</u> Year <u>19 67</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-26-1888</u>	
9. AGE (in years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis P. Oates</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Harlon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216464035</u>		17. INFORMANT <u>J. Edwin Oates</u> Address <u>103 Springside Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vascular Collapse</u> <u>903.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Arteriosclerosis</u> (c) <u>with Superior</u> <u>Fracture of Femur</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell on floor of Home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30</u> p.m. <u>Dec 27 19 66</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) (County) (State) <u>Balto. City</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				7501 York Rd. BALTO. MD. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22. DATE SIGNED <u>1/6/67</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 8 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove suchon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01752

CERTIFICATE OF DEATH

01749

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD,			c. LENGTH OF STAY IN 1b 245 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 671 S. WICKHAM ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CHRISTIAN BRANDT				4. DATE OF DEATH Month Day Year FEBRUARY 15 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH OCTOBER 8, 1893	
9. AGE (In years last birthday) yrs. 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME FREDERICK BRANDT			
14. MOTHER'S MAIDEN NAME MARY DAUM				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI			
16. SOCIAL SECURITY NO. 218 03 83 97				17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LAENNEC'S CIRRHOSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 DAYS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF PROSTATE. POST OPERATIVE REMOVAL OF MENINGIOMA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (V) (this hospital) attended the deceased from MAY 17 , 19 66 , to FEB. 15 , 19 67 , that (V) (we) last saw the deceased alive on FEB 15 , 19 67 , and that death occurred on 551A M, from causes on and on the date stated above.							
22a. SIGNATURE <i>George C. McElpatrick</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/15/67	
22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/17/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR AMBROSE FUNERAL HOME				25a. REC'D BY REGISTRAR FEB 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. ADDRESS 41 ARBUTUS, MARYLAND							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01753					01750						
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>BALTO</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>			c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9755 Magledt Rd</u>					d. STREET ADDRESS <u>9755 Magledt Rd</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			
3. NAME OF DECEASED (Type or print) <u>ALPHONSES</u>		First Middle Last <u>J. BRAUN</u>		4. DATE OF DEATH <u>Feb 10 1967</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26-1886</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - BALTO</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John P. BRAUN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-36-3788</u>		17. INFORMANT <u>MINNIE BRAUN</u> Address <u>SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriovascular Disease</u> <u>4201</u> DUE TO <u>with myocardial degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Coronary Artery Disease, Prosthetic Hypertension</u>										19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> to <u>Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 7 1967</u> , and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank J. Kasik</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/11/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>FRANK J. KASIK</u>				22d. ADDRESS <u>9005 Hartford Rd</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST Joseph</u>		23d. LOCATION (City, town or county) (State) <u>Fulton Md</u>					
24. FUNERAL DIRECTOR <u>Chas. F. Evans & Son</u>				ADDRESS <u>8802 Hartford Rd</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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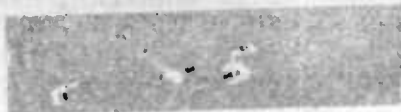
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01754						01751					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Baltimore Co.</u>			MARYLAND			a. STATE <u>Md.</u>			b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
						<u>White Hall</u>			<u>03-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
<u>Greater Baltimore Medical Center</u>						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
<u>Baby First Girl Bridges</u>						<u>2 23 1967</u>					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<u>Female</u>		<u>Cauc.</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>2-17-67</u>		<u>2</u> yrs.		<u>6</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
<u>Cable</u>				<u>At Home</u>		<u>Baltimore Co., Md.</u>			<u>USA</u>		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
<u>Edward Bridges</u>						<u>Sara Katherine Saunders</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
<u>No</u>				<u>None</u>		<u>Admission (Birth Information) Chart</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7542</u> <u>congenital heart disease - asymptomatic (interventricular septal defect)</u>											
DUE TO (b) <u>congenital heart disease - asymptomatic (interventricular septal defect)</u>											
DUE TO (c) <u>congenital heart disease - asymptomatic (interventricular septal defect)</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<u>Osphthalocoele</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <u>2-17-</u> , 19 <u>67</u> , to <u>2-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-22</u> 19 <u>67</u> , and that death occurred at <u>4:50</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
<u>Christine Simon</u>									<u>2-23-67</u>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>Feb. 25, 1967</u>		<u>Vernon Methodist Cemetery</u>		<u>White Hall, Maryland</u>					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>John Burns' Sons, Towson, Md.</u>						<u>FEB 27 1967</u>			<u>Charles Judge</u>		
<u>7-274164</u>											

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01755

CERTIFICATE OF DEATH

01752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 928 NORTH MADEIRA STREET	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last BRIGHT		4. DATE OF DEATH Month FEBRUARY Day 27 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 17 96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRER		10b. KIND OF BUSINESS OR INDUSTRY BRASS FOUNDRY	9. AGE (In years last birthday) yrs. 70
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE E. BRIGHT		14. MOTHER'S MAIDEN NAME Sophie Oberlander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 217 01 30 96	
17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 465X IMMEDIATE CAUSE (a) PULMONARY EMBOLUS DUE TO — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. xx24x (b) DUE TO MALNUTRITION, DEHYDRATION (c)			INTERVAL BETWEEN ONSET OF DEATH VEINS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS; OLD FRACTURE LEFT FEMORAL NECK; HIPS CONTRACTURES; DECUBITUS.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 23 , 19 67 , to Feb. 27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 27 , 19 67 , and that death occurred 3:30 a.m. from causes and on the date stated above.			
22a. SIGNATURE Neilson Neilson		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-2-67	23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER Cemetery	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR Philip F. Leach		25a. REC'D BY REGISTRAR MAR 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01756 **CERTIFICATE OF DEATH** **01753**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Convalescent Home</u>				d. STREET ADDRESS <u>6421 Cedonia Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry E.</u> Middle <u>Bruchey</u> Last			4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29, 1876</u>		9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bruchey</u>				14. MOTHER'S MAIDEN NAME <u>Susan -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-12-3905</u>		17. INFORMANT <u>John E. Lilly - 28 Beech Drive - 21220</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>9 Feb 1967</u> , that (I) (we) last saw the deceased alive on <u>9 Feb 1967</u> , and that death occurred at <u>3:40 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Goodman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10 Feb 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, MD</u>				22d. ADDRESS <u>1332 Tulphur Lane Rt-21227</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Road-21206</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

01523

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

01757

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01754

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b One Week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 307 Bayside Drive		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 307 Bayside Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle E. Last Bryant		4. DATE OF DEATH Month February Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/90
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maine	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Crocker		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-24-2212	
17. INFORMANT June Stipek, 8341 Bear Creek Dr. Dundalk,		Address Md. 21222	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza - Cardiac Failure (c) Arterio - Sclerosis - Hypertension INTERVAL BETWEEN ONSET AND DEATH 1 day 1 week 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to 2/24 , 19 67 that (I) (we) last saw the deceased alive on 2/24 19 67 , and that death occurred at A. M. from the causes and on the date stated above.			
22a. SIGNATURE Morris A. Jacobs		22b. DATE SIGNED 2/27/67	
22c. PHYSICIAN'S NAME (Type) Morris A. Jacobs		22d. ADDRESS M. D. 1010 North Point Rd. Dundalk, Md. 21224	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/28/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR FEB 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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1. *B*
FOR STATE
HEALTH DEPT.

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

<div> <div> <div>1. PLACE OF DEATH</div> <div> <div>e. COUNTY</div> <div>Baltimore</div> </div> </div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)</div> <div> <div>e. STATE</div> <div>Maryland</div> </div> <div> <div>b. COUNTY</div> <div>Baltimore</div> </div> </div> </div>															
<div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Edgemere</div> </div>				<div> <div>c. LENGTH OF STAY IN 1b</div> <div></div> </div>				<div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Edgemere</div> </div>				<div> <div>d. STREET ADDRESS</div> <div>7207 Bucher Road</div> </div>			
<div> <div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>7207 Bucher Road</div> </div>				<div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div> </div>											
<div> <div>3. NAME OF DECEASED (Type or print)</div> <div>ANN</div> </div>				<div> <div>First</div> <div>BUCHER</div> </div>				<div> <div>Last</div> <div></div> </div>				<div> <div>4. DATE OF DEATH</div> <div>February 9 1967</div> </div>			
<div> <div>5. SEX</div> <div>Female</div> </div>		<div> <div>6. COLOR OR RACE</div> <div>White</div> </div>		<div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div>		<div> <div>8. DATE OF BIRTH</div> <div>Dec. 22, 1901</div> </div>		<div> <div>9. AGE (In years last birthday)</div> <div>65 yrs.</div> </div>		<div> <div>IF UNDER 1 YEAR</div> <div>Months Days</div> </div>		<div> <div>IF UNDER 24 HRS.</div> <div>Hours Min.</div> </div>			
<div> <div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Housewife</div> </div>				<div> <div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Own Home</div> </div>				<div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>Baltimore, Maryland</div> </div>				<div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div></div> </div>			
<div> <div>13. FATHER'S NAME</div> <div>Peter Bestry</div> </div>				<div> <div>14. MOTHER'S MAIDEN NAME</div> <div>Maryanna</div> </div>											
<div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</div> <div>No</div> </div>				<div> <div>16. SOCIAL SECURITY NO.</div> <div></div> </div>				<div> <div>17. INFORMANT</div> <div>Martin R. Bestry</div> </div>				<div> <div>Address</div> <div>5703 Belle Vista Ave.</div> </div>			
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>A-S-C-V- Disease</div> </div> <div> <div>4221</div> <div>DUE TO</div> <div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b)</div> <div>DUE TO</div> <div>(c)</div> </div> </div> </div>												<div> <div>INTERVAL BETWEEN ONSET AND DEATH</div> <div></div> </div>			
<div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div> <div></div> </div>														<div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>	
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></div> <div></div> </div>				<div> <div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</div> <div>No</div> </div>											
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div> <div>19</div> </div>				<div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div>		<div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div></div> </div>		<div> <div>20f. (City or town)</div> <div></div> </div>		<div> <div>(County)</div> <div></div> </div>		<div> <div>(State)</div> <div></div> </div>			
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from</div> <div> <div>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> </div> </div>															
<div> <div>ACTUAL SIGNATURE</div> <div>M.B. Davis</div> </div>				<div> <div>CHIEF MEDICAL EXAMINER</div> <div></div> </div>				<div> <div>ASSISTANT MEDICAL EXAMINER</div> <div></div> </div>				<div> <div>DEPUTY MEDICAL EXAMINER</div> <div></div> </div>			
<div> <div>EXAMINER'S NAME (Type)</div> <div>M.B. Davis MD - 6800</div> </div>				<div> <div>DATE SIGNED</div> <div>2/10/67</div> </div>											
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>				<div> <div>22b. DATE THEREOF</div> <div>2-11-1967</div> </div>		<div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Holy Rosary</div> </div>				<div> <div>22d. LOCATION (City, town, or country)</div> <div>Baltimore County, Maryland</div> </div>					
<div> <div>23. FUNERAL DIRECTOR</div> <div>Lilly & Zeiler Inc.</div> </div>				<div> <div>24a. REC'D BY REGISTRAR</div> <div>FEB 10 1967</div> </div>				<div> <div>24b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div> </div>							

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22510

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01759						01756					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Baltimore			Catonsvill			Maryland			Baltimore		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
MIDDLE			Paradise Nursing Home			Arbutus			1314 Birch Ave.		
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?			6. IS RESIDENCE ON A FARM?		
First Middle Last			Month Day Year			YES NO			YES NO		
Anna E. Burns			February 15 1967			YES NO			YES NO		
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED		November 14 1881		85 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Housework				Own Home				Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John V. Schwarzkopf						UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT			
No								Catherine Radenhi			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. WAS AUTOPSY PERFORMED?				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				① Cerebral thrombosis				Immediate			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) ② Chronic Brain Syndrome				5 yrs			
				(c) associated with Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m.				While at work Not While at work				20f. (City or town) (County) (State)			
19								4/9/65 2/15/67			
21. I certify that (I) (this hospital) attended the deceased from 4/9/65, 19, to 2/15/67, 19, that (I) (we) last saw the deceased alive on 2/13/1967, and that death occurred at 12 PM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
W.E. McGrath						2/17/67					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
W.E. McGrath						1303 Frederick Ave. Catonsville Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY			
Burial				2/18/67				Holy Redeemer Cemetery Baltimore Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Ambrose Inc 1328 Sulphur Spring Rd.				DATE							

01325

01325

① Chronic liver syndrome
② Chronic liver syndrome
③ Chronic liver syndrome

8/1/67

8/1/67

1/1/68

8/1/67

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01760

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01757

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown Pikesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Newell Funeral Home				d. STREET ADDRESS 9309 Liberty Road			
3. NAME OF DECEASED (Type or print) First Orville Middle Clayton Last BURNSIDE				4. DATE OF DEATH Month February Day 22 , Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 7, 1931		9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months 0 Days 3 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHUCKER		10b. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Burnside				14. MOTHER'S MAIDEN NAME CORDIA --			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1958-1954		16. SOCIAL SECURITY NO. 248-26-5843		17. INFORMANT Mrs. Dorcas C. Charney 102 N. Charter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold associated with acute alcoholism 9325 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) side of road				INTERVAL BETWEEN ONSET AND DEATH G.B., 1 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fatty metamorphosis of liver				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposed to cold					
20c. TIME OF INJURY Month, Day, Year Hour a.m. ? p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) side of road		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		22. DATE SIGNED February 23, 1967		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF March 1, 1967		23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. Cem		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hwy				25a. REC'D BY REGISTRAR MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01761

CERTIFICATE OF DEATH

01758

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3025 Chesley Avenue	
3. NAME OF DECEASED (Type or print) First Euly Middle H. Last Burtch		4. DATE OF DEATH Month February Day 1 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-92
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Western Electric	
11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elwood Burtch		14. MOTHER'S MAIDEN NAME Christina Paulstring	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-9572A	
17. INFORMANT Mrs. Grace Burtch		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.5 Intestinal infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) possible strangulated hernia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from Jan. 30 , 19 67 , to Feb. 1 , 19 67 , that NO (we) last saw the deceased alive on Feb. 1 , 19 67 , and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence F. Misanik</i> M.D.		22b. DATE SIGNED Feb. 1, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/4/67.	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR FEB 6 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

01755

01755

01755

TO BE RETURNED TO THE
LIBRARY OF THE
U.S. DEPARTMENT OF
COMMERCE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01762

CERTIFICATE OF DEATH

01759

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 17 yrs.		d. STREET ADDRESS 6606 Windsor Mill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6606 Windsor Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Evelyn Middle L. Last Burton		4. DATE OF DEATH Month February Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-26-1896
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 13 Days 3 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Benjamin Franklin Lang		14. MOTHER'S MAIDEN NAME Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Evelyn M. Burton		Address -6606 Windsor Mill Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE Philip Bernstein M.D.		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-4-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Edward Amico		25a. REC'D BY REGISTRAR DATE FEB 6 1967	
ADDRESS 4600 Liberty Hgts. Avenue		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

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1234567891011121314151617181920212223242526272829303132333435363738394041424344454647484950515253545556575859606162636465666768697071727374757677787980818283848586878889909192939495969798991001011021031041051061071081091101111121131141151161171181191201211221231241251261271281291301311321331341351361371381391401411421431441451461471481491501511521531541551561571581591601611621631641651661671681691701711721731741751761771781791801811821831841851861871881891901911921931941951961971981992002012022032042052062072082092102112122132142152162172182192202212222232242252262272282292302312322332342352362372382392402412422432442452462472482492502512522532542552562572582592602612622632642652662672682692702712722732742752762772782792802812822832842852862872882892902912922932942952962972982993003013023033043053063073083093103113123133143153163173183193203213223233243253263273283293303313323333343353363373383393403413423433443453463473483493503513523533543553563573583593603613623633643653663673683693703713723733743753763773783793803813823833843853863873883893903913923933943953963973983994004014024034044054064074084094104114124134144154164174184194204214224234244254264274284294304314324334344354364374384394404414424434444454464474484494504514524534544554564574584594604614624634644654664674684694704714724734744754764774784794804814824834844854864874884894904914924934944954964974984995005015025035045055065075085095105115125135145155165175185195205215225235245255265275285295305315325335345355365375385395405415425435445455465475485495505515525535545555565575585595605615625635645655665675685695705715725735745755765775785795805815825835845855865875885895905915925935945955965975985996006016026036046056066076086096106116126136146156166176186196206216226236246256266276286296306316326336346356366376386396406416426436446456466476486496506516526536546556566576586596606616626636646656666676686696706716726736746756766776786796806816826836846856866876886896906916926936946956966976986997007017027037047057067077087097107117127137147157167177187197207217227237247257267277287297307317327337347357367377387397407417427437447457467477487497507517527537547557567577587597607617627637647657667677687697707717727737747757767777787797807817827837847857867877887897907917927937947957967977987998008018028038048058068078088098108118128138148158168178188198208218228238248258268278288298308318328338348358368378388398408418428438448458468478488498508518528538548558568578588598608618628638648658668678688698708718728738748758768778788798808818828838848858868878888898908918928938948958968978988999009019029039049059069079089099109119129139149159169179189199209219229239249259269279289299309319329339349359369379389399409419429439449459469479489499509519529539549559569579589599609619629639649659669679689699709719729739749759769779789799809819829839849859869879889899909919929939949959969979989991000100110021003100410051006100710081009101010111012101310141015101610171018101910201021102210231024102510261027102810291030103110321033103410351036103710381039104010411042104310441045104610471048104910501051105210531054105510561057105810591060106110621063106410651066106710681069107010711072107310741075107610771078107910801081108210831084108510861087108810891090109110921093109410951096109710981099110011011102110311041105110611071108110911101111111211131114111511161117111811191120112111221123112411251126112711281129113011311132113311341135113611371138113911401141114211431144114511461147114811491150115111521153115411551156115711581159116011611162116311641165116611671168116911701171117211731174117511761177117811791180118111821183118411851186118711881189119011911192119311941195119611971198119912001201120212031204120512061207120812091210121112121213121412151216121712181219122012211222122312241225122612271228122912301231123212331234123512361237123812391240124112421243124412451246124712481249125012511252125312541255125612571258125912601261126212631264126512661267126812691270127112721273127412751276127712781279128012811282128312841285128612871288128912901291129212931294129512961297129812991300130

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01763

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01760

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> <u>03-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>51 SEVERSKY CT.</u>				d. STREET ADDRESS <u>51 SEVERSKY CT.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>SALLIE ANN BUTTERWORTH</u> First Middle Last				4. DATE OF DEATH Month <u>FEB</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 25 1895</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTIAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. DEMPSEY</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>POLYCEMIA RUBRA -</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drop</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Drop</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. DAVIS M.D. - 6800 MORNHILL AVE. BALTIMORE, MD.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>2/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PRINCETON</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCETON W. VA</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>				ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE	

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2. The World

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01761

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7727 E. Baltimore St.				d. STREET ADDRESS 7713 E. Baltimore St.			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle CAREY Last CAREY				4. DATE OF DEATH Pronounced February 25 Day 19 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/64	9. AGE (In years lost birthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBT C. CAREY SR.				14. MOTHER'S MAIDEN NAME MILDRED BALTZ CAREY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address R.C. CAREY 7727 E BALTO ST			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carbon monoxide DUE TO (c) Conflagration						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fire in row house					
20c. TIME OF INJURY Month, Day, Year Hour 11:40 p.m. 2-24 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-25-67	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/28/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR ADDRESS J. G. CONNELLY SON 300 MACE				25a. REC'D BY REGISTRAR MAR 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 01765 CERTIFICATE OF DEATH 01762													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> c. LENGTH OF STAY IN 1b <u>24 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monkton Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u> d. STREET ADDRESS <u>Monkton Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>W.</u> Last <u>Carroll</u>				4. DATE OF DEATH <u>February 14</u> 19 <u>67</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22, 1884</u>		9. AGE (In years last birthday) <u>82</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Daniel S. Wilhelm</u>				14. MOTHER'S MAIDEN NAME <u>Tacie B. Morris</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>John A. Carroll, Monkton Rd., Monkton, Md.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio sclerosis C.V. Disease</u> DUE TO (c) <u>Hypertension C.V. Disease</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>60</u> , to <u>2-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-14</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <u>Herbert Mueller Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-18-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>E. HERBERT MUELLER JR.</u>				22d. ADDRESS <u>PARKTON MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Febr. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Methodist</u>		23d. LOCATION (City, town or county) (State) <u>Fawn Grove Penna.</u>							
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>FEB 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01766

CERTIFICATE OF DEATH

01763

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor N.H.		d. STREET ADDRESS 3914 Cloverhill Rd.	
3. NAME OF DECEASED (Type or print) John H. Latrobe		4. DATE OF DEATH Month February Day 2nd Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy Inspector		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) N.J.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew K. Cogswell		14. MOTHER'S MAIDEN NAME Virginia Latrobe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 180-24-5800A	
17. INFORMANT Mrs. John Heyrman		Address Balto., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASHD DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan , 1960, to Feb 2 , 1967, that (I) (we) last saw the deceased alive on Feb 2 , 1967, and that death occurred at 3:05 P.M. from causes and on the date stated above.			
22a. SIGNATURE F.M. DUGAN		22b. DATE SIGNED 2/3/67	
22c. PHYSICIAN'S NAME (Type) F.M. DUGAN		22d. ADDRESS 15 E Belknap St Baltimore 21202	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-4-67	23c. NAME OF CEMETERY OR CREMATORY Greenmount	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR DATE FEB 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01767

01764

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1415 Woodcliff Avenue 28				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1415 Woodcliff Avenue 28 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Julia A. Coleman		4. DATE OF DEATH Month February Day 8 Year 1967		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 5, 1889		9. AGE (In years last birthday) 78 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME Isaac E. Gardner						14. MOTHER'S MAIDEN NAME India Hook															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) None				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Herbert Pinkston Address same address as above													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL</u>, 1960, to <u>FEB 8</u>, 1967, that (I) (we) last saw the deceased alive on <u>FEB 8</u>, 1967, and that death occurred at <u>11</u> M, from the causes and on the date stated above.																					
22a. SIGNATURE Thomas E. Wheeler MD M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/9/67		22c. ADDRESS Randall Station - Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/11/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION (City, town or county) Baltimore, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fickner & Sons						25a. REC'D BY REGISTRAR DATE FEB 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01769

CERTIFICATE OF DEATH

01766

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4750 Westland Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HENRIETTA R. CONNOR First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				4. DATE OF DEATH February 1, 19 67 Month Day Year 8. DATE OF BIRTH 4-13-1903 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Otto Schroen 14. MOTHER'S MAIDEN NAME Catherine M. Crou			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Marie F. Walters, 1001 DeSota Road				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hyperostotic Cardiovascular Disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Oct 21, 1948 , to Feb 1, 1967 , that (I) (we) last saw the deceased alive on Jan 31 1967 , and that death occurred at 9:30 M, from causes and on the date stated above. 22a. SIGNATURE Dr. A. Bradley Daugharthy M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Dr. A. Bradley Daugharthy 22d. ADDRESS 1264 Francis Avenue 22b. DATE SIGNED Feb 2, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2-4-1967 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland				24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229 25a. REC'D BY REGISTRAR DATE FEB 3 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is detached, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CONTRACT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY BALTO MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON MD c. LENGTH OF STAY IN 1b 3 YRS 3 MO d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FOXLEIGH NURSING HOME					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Ambassador Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARTHA			First Middle Last CONNOR		4. DATE OF DEATH Month 2 Day 18 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 29 1882		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist-Designer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. James Conner					14. MOTHER'S MAIDEN NAME Jane Hallowell				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. None		17. INFORMANT Janet Stover, 11 Northampton Rd. Timonium Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) left sided hemiplegia DUE TO (c) general arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 2 days several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15-19 , to 2-18-19 , that (I) (we) last saw the deceased alive on 2-17-19 , and that death occurred at 3:00 M, from the causes and on the date stated above.									
22a. SIGNATURE James B. Saffell								22b. DATE SIGNED 2-18-67	
22c. PHYSICIAN'S NAME (Type) James B. Saffell MD				22d. ADDRESS Reisterstown, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 21, 67		23c. NAME OF CEMETERY OR CREMATORY Barratts Chapel		23d. LOCATION (City, town or county) (State) Frederica, Del.		
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204				ADDRESS		25a. REC'D BY REGISTRAR FEB 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23c Film #0386 3/50/67 ps

01771

CERTIFICATE OF DEATH

01768

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 4mth28dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth Middle Cook Last Cook		4. DATE OF DEATH Month February Day 11 Year 1967	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1916
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		12. KIND OF BUSINESS OR INDUSTRY none	
13. BIRTHPLACE (County & State, or foreign country) North Carolina		14. CITIZEN OF WHAT COUNTRY? U.S.	
15. FATHER'S NAME Issah Cook		16. MOTHER'S MAIDEN NAME Maggie Harris	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		18. SOCIAL SECURITY NO. unknown	
19. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma, old DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage DUE TO (c) Arteriosclerotic cerebral vascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 mths. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized: Arteriosclerotic cardiovascular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heart disease	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from June 4, 1966 to Feb. 11, 1967 , that he (we) last saw the deceased alive on Feb. 11, 1967 , and that death occurred at 4:00 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 2-14-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Anatomy Board		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2
MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01772

CERTIFICATE OF DEATH

01769

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 8619 Black Oak Rd. 21234	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Corder		4. DATE OF DEATH Month Feb. Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/90
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 13 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. HANCOCK		14. MOTHER'S MAIDEN NAME ISABELLE SCHRADER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Mary E. Seinkuhler - 8619 Black Oak Rd	
17. INFORMANT Address Balto, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Respiratory failure DUE TO Pleural effusion (b) Pulmonary Cancer DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Congenital heart failure due to arteriosclerotic cardio-vascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Feb. 15 , 19 67 to Feb. 24 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 24 , 19 67 , and that death occurred at 10:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Nelson S. de la Paz M.D.		22b. DATE SIGNED Feb. 24, 1967	
22c. PHYSICIAN'S NAME (Type) Nelson S. de la Paz, M.D.		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-28-67	
23c. NAME OF CEMETERY OR CREMATORY HANCOCK CEMETERY		23d. LOCATION (City or Town) (County) (State) LITTLE CREEK, VA.	
24. FUNERAL DIRECTOR Harley Miller - 2334 Jefferson St.		25a. REC'D BY REGISTRAR MAR 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

01750

01778

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILLINOIS
JAN 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>21215</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>21215</u> d. STREET ADDRESS <u>4644 Pall Mall Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Cox</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>9</u> Year <u>1967</u>															
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/16/1877</u>		9. AGE (In years last birthday) <u>89</u> yrs. <table border="1"> <tr> <th>IF UNDER 1 YEAR</th> <th>Months</th> <th>Days</th> <th>IF UNDER 24 HRS.</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR	Months	Days	IF UNDER 24 HRS.	Hours	Min.						
IF UNDER 1 YEAR	Months	Days	IF UNDER 24 HRS.	Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Upperco, Md.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>Thomas Alban</u>						14. MOTHER'S MAIDEN NAME <u>Resh</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>213-36-3749</u>		17. INFORMANT <u>Mrs. James A. Reidler, Jr.</u> Address <u>21207 3700 Campfield Rd</u>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular</u> <u>4221</u> DUE TO <u>Dissect.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Large Drepnregmatic Hernia - 5 yrs.</u>																					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/62</u> , to <u>2/9/67</u> , that (I) (we) last saw the deceased alive on <u>2/8/67</u> , and that death occurred at <u>800A</u> M, from the causes and on the date stated above.																					
22a. SIGNATURE <u>W E Mc Greth MD</u>						22b. DATE SIGNED <u>2/9/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W E Mc Greth MD</u>		22d. ADDRESS <u>1303 Frederick Rd 28</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem E. U. B.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, County, Md.</u>													
24. FUNERAL DIRECTOR <u>Loring Byers - 3728 Liberty Rd. Randallstown, Md</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>															

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01774

01771

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 405 N. Duncan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THOMAS Middle JOSEPH Last COX				4. DATE OF DEATH Month FEBRUARY Day 17 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/13	9. AGE (In years last birthday) yrs. 53	IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Cox				14. MOTHER'S MAIDEN NAME Anna Drehoff			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 216-05-47-34		17. INFORMANT Address Clinical Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE FROM DUODENAL ULCER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) POLYCYTHEMIA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Minutes Weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 14 , 1967, to Feb. 17 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 17 , 1967, and that death occurred at 5:00PM from causes and on the date stated above.							
22a. SIGNATURE <i>Sheldon E. Kalmutz</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/18/67	
22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M.D.				22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/21/67		23c. NAME OF CEMETERY OR CREMATORY Bohemian Natl Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR <i>Phillip Herwig & Sons</i>				25a. REC'D BY REGISTRAR St. Charles Judge		25b. REGISTRAR'S SIGNATURE <i>St. Charles Judge</i>	
PHILLIP HERWIG & SONS FUNERAL HOME Balto, Md. DATE FEB 20 1967							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01775 | | | | | CERTIFICATE OF DEATH | | | 01772 | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
4 mths 2 dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Aberdeen, Maryland | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | | d. STREET ADDRESS
649 West Bel Air Avenue | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
George John Creswell | | | | | 4. DATE OF DEATH
Month Day Year
February 20 19 67 | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 2, 1893 | | 9. AGE (In years last birthday)
72 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maint. Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad (B&O) | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | | |
| 13. FATHER'S NAME
William Creswell | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
705-09-7392 | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
(c) Generalized arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Malnutrition - Dehydration | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (a) (this hospital) attended the deceased from Jan. 8 , 19 60 to Feb. 20 , 19 67 , that (b) (we) last saw the deceased alive on Feb. 20 , 19 67 , and that death occurred at 9:00 M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Stella Wachsler | | | | | P. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
M.D. <input type="checkbox"/> | | | 22b. DATE SIGNED
2-20-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachsler, M.D. | | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
23 Feb. 67 | | 23c. NAME OF CEMETERY OR CREMATORY
Bakers Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Aberdeen Harford Md. | | |
| 24. FUNERAL DIRECTOR
John E. Tarrington
Aberdeen, Maryland | | | | | 25a. REC'D BY REGISTRAR
DATE
FEB 23 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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1947 1948

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1965 1966

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01776

CERTIFICATE OF DEATH

01773

ITEM 4-Tel. Call Vets. Hosp. 3/1/67mnb

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD
c. LENGTH OF STAY in lb
42 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE
d. STREET ADDRESS
10316 GREENTOP ROAD
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First GEORGE Middle B. Last CROFT | | 4. DATE OF DEATH
Month FEBRUARY Day 23 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUGUST 13, 1924 |
| 9. AGE (In years last birthday)
42 | | 10. IF UNDER 1 YEAR
Months 12 Days 19 Hours 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MECHANIC | | 10b. KIND OF BUSINESS OR INDUSTRY
AUTOMOBILE | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE A. CROFT | | 14. MOTHER'S MAIDEN NAME
DAISY MYERS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
214 22 45 79 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA, BILATERAL
DUE TO
(b) DIABETIC NEPHROPATHY, NEPHROTIC SYNDROME
DUE TO
(c) DIABETES MELLITUS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
ARTERIOSCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH
DAYS
UNKNOWN
UNKNOWN | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/12/67 , 19__, to 2/23/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/23/67 , 19__, and that death occurred at 8:25AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
L. L. Neilson | | 22b. DATE SIGNED
2/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
NEILON NEILSON, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-27-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY MEM. GARDENS BALTIMORE CO. MD. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
WM COOK BROOKS TOWSON | | 25a. REC'D BY REGISTRAR
DATE FEB 28 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01738

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01777

CERTIFICATE OF DEATH

01774

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital, 7620 York Rd. 21204 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ROMEO Middle (Ray) Last D'ADAMO | | 4. DATE OF DEATH
Month Feb. Day 12 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-7-13 |
| 9. AGE (In years last birthday)
53 yrs. | | IF UNDER 1 YEAR
Months — Days — | IF UNDER 24 HRS.
Hours — Min. — |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Building Inspector | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore City | 11. BIRTHPLACE (County & State, or foreign country)
New York |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
James D'Adamo | |
| 14. MOTHER'S MAIDEN NAME
Gioconda Pezzalla | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes | |
| 16. SOCIAL SECURITY NO.
107-126313 | | 17. INFORMANT
Louise D'Adamo Address same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetes Mellitus
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour — a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-19-67 , 19 — , to 2-12-67 , 19 — , that (I) (we) last saw the deceased alive on 2-12-67 , 19 — , and that death occurred at 4:00p M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Arturo A. Pidlaoan MD | | 22b. DATE SIGNED
2-12-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Arturo Pidlaoan, M.D. | | 22d. ADDRESS
7620 York Road, Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
2-16-67 | 23c. NAME OF CEMETERY OR CREMATORY
Riverhurst Cemetery | 23d. LOCATION (City or Town) (County) (State)
Endicott, New York |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc Baltimore, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE FEB 14 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIPT OF CASH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01778

CERTIFICATE OF DEATH

01775

| | | | |
|--|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN 1b
<u>3 mo. 9 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | 30-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | d. STREET ADDRESS
<u>1900 W. BALTIMORE ST.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>HELEN</u> Middle <u>LORETTA</u> Last <u>DAUGHTON</u> | | 4. DATE OF DEATH
Month <u>FEBR.</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-13-1891</u> |
| 9. AGE (In years last birthday)
<u>75</u> yrs. | | IF UNDER 1 YEAR
Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cleaning (Ret)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>BANKS</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JOHN ARTHUR</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY GREENE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. INFORMANT
<u>CHARLES DAUGHTON</u> Address <u>GLEN BURNE, Md.</u> | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CIRCULATORY INSUFFICIENCY</u>
<u>4221</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CARDIAC INSUFFICIENCY</u>
DUE TO
(c) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 h. 45'</u>
<u>27 YRS.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>---</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> , 19 <u>66</u> , to <u>Feb. 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 18</u> , 19 <u>67</u> , and that death occurred at <u>5:25</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Morris Meiller</u> | | 22b. DATE SIGNED
<u>2/18/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MORRIS MEILLER</u> | | 22d. ADDRESS
<u>1130 BAKER AVE. - BALTO. MD. 21207</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>2/21/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Woodlawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Woodlawn Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>T.V. Singleton</u> | | 25. REC'D BY REGISTRAR
<u>Glen Burnie, Md.</u> | |
| 25a. DATE
<u>FEB 21 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01775

CENTRAL FILE OF DEATHS

01775

WCV

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01779 CERTIFICATE OF DEATH 01776

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Howard | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Ellicott City, | | d. STREET ADDRESS
Rt. 2 Box 51 A | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
THOMAS EVANS DAVIS | | 4. DATE OF DEATH
Month
Feb. 9, 1967 | | Day
19 | | Year
19 | | 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 5, 1879 | | 9. AGE (In years last birthday)
87 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Woodstock, Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Davis | | 14. MOTHER'S MAIDEN NAME
Sallie E. Gorsuch | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
1-20-1967 | | 17. INFORMANT
Mary E. Davis, Rt. 2, Ellicott City, Md | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c) 15 yrs. | | INTERVAL BETWEEN ONSET AND DEATH
10 days | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | 21. I certify that (I) (this hospital) attended the deceased from 1-20-1967 , to 2-9-1967 , that (I) (we) last saw the deceased alive on 2-8-1967 , and that death occurred at 8:30 AM , from the causes and on the date stated above. | | 22a. SIGNATURE
Wilmer K. Gallagher Jr. | | 22b. DATE SIGNED
2-10-67 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher, Jr. | | 22d. ADDRESS
6209 Frederick Ave. Balt. 28, Md. | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22f. ATTENDING PHYS. <input checked="" type="checkbox"/> | | 22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22h. ATTENDING PHYS. <input checked="" type="checkbox"/> | | 22i. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22j. ATTENDING PHYS. <input checked="" type="checkbox"/> | | 22k. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-11-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Family | | 23d. LOCATION (City, town or county)
Harrissonville, Md | | (State) | | 24. FUNERAL DIRECTOR
F.C. Higginbotham | | 25a. REC'D BY REGISTRAR
FEB 14 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | 25c. DATE
FEB 14 1967 | | | | | | | |

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]

1-25-41 41-2-8

6-3-41

[Faint text, possibly names or titles, including "William H. Hall" and "John H. Hall".]

[Faint text at the bottom of the page, possibly a signature or date.]

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01777

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>md</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>76 Hillview</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 30-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veteran Administration Hospital</u> | | d. STREET ADDRESS <u>448 Pitman Place</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>DAVIS</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 28, 1928</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Suburban</u> | | 11. BIRTHPLACE (State or foreign country) <u>Framville N.C.</u> | |
| 13. FATHER'S NAME <u>Tom Davis</u> | | 14. MOTHER'S MAIDEN NAME <u>Nina Stanvil</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>9160</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u>
9160
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>2nd + 3rd Degree Burns</u>
(c) <u>Back, arms & Hands</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>2 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>7/2</u> p.m. <u>167</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Baltimore</u> (County) <u>md</u> (State) <u>md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Theo C. Patterson</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>THEO. C. PATTERSON</u> | | M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>Feb 21/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Hall Cem.</u> | | 23d. LOCATION (City, town or county) <u>Balto md</u> (State) | |
| 24. FUNERAL DIRECTOR <u>Walter E. Elicker 1129 N. Coxland</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01781

CERTIFICATE OF DEATH

01778

| | | | | | | | |
|--|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonville</u> | | | c. LENGTH OF STAY IN 1b
<u>1yr3mth14dys</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Middle River, Maryland</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | | | d. STREET ADDRESS
<u>Route 15 - Box 712</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Mary</u> Middle <u>L.</u> Last <u>Delanty</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5. SEX
<u>female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Nov. 6, 1900</u> | |
| 9. AGE (In years last birthday)
<u>66</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>John McGinty</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Stauder</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>706-16-7551</u> | | 17. INFORMANT Address
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary embolism, acute</u>
<u>466X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis, right leg</u>
DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u> </u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> o.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that <u> </u> (this hospital) attended the deceased from <u>Oct. 12</u> , 19 <u>65</u> , to <u>Feb. 3</u> , 19 <u>67</u> that <u> </u> (we) last saw the deceased alive on <u>Feb. 3</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Anthony J. Young, M.D.</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-3-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Anthony J. Young, M.D.</u> | | | | 22d. ADDRESS
<u>SPRING GROVE STATE HOSPITAL</u>
<u>Baltimore, Maryland 21228</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington Mthl.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Arlington Va.</u> | |
| 24. FUNERAL DIRECTOR
<u>J. H. Connolly Sons</u> | | | | 25a. REC'D BY REGISTRAR
<u>300 more</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| | | | | DATE
<u>FEB 7 1967</u> | | | |

0158

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #G386 3/10/67 pc

01782

CERTIFICATE OF DEATH

03171

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
33yr10mth10dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
1024 Denver Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Arthur Delker First Delker Middle a.k.a. Last Delcher | | | | 4. DATE OF DEATH
Month February Day 27 Year 19 67 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 20, 1899 | 9. AGE (In years last birthday)
68 yrs. | 10. IF UNDER 1 YEAR
Months 28 Days 4 Hours 10 Min. | | 11. IF UNDER 24 HRS.
Months 0 Days 0 Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
George | | | | 14. MOTHER'S MAIDEN NAME
Carrie Myers | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
Carcinoma of cecum | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from April 17 , 19 66 , to Feb. 27, 1967 , that (I) was last saw the deceased alive on Feb. 27 , 19 67 , and that death occurred at 2:30 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar | | 22b. DATE SIGNED
2-28-67 | | 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | | |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)
RE-7-67 | | 23b. DATE THEREOF
7-7-67 | | 23c. NAME OF CEMETERY OR CREMATORY
U. S. and Med. School | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Newell Funeral Home Baltimore - 8-114 | | 25a. REC'D BY REGISTRAR
MAR 8 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

03171

0178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 01783 | | | | Item #23b | | | | 01779 | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Monkton | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Monkton - Avondale | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) York Road at Hereford | | | | | d. STREET ADDRESS York Road at Hereford | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Jennie | | | | | 4. DATE OF DEATH February 11 19 67 | | | | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/7/1885 | | 9. AGE (In years last birthday) 81 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State, or foreign country) Hereford, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | |
| 13. FATHER'S NAME Dr. Alexander Mitchell | | | | | 14. MOTHER'S MAIDEN NAME Edith Stockton Conway | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Mrs. J. Elliott Mays, Avondale, Monkton, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4201
DUE TO (b) Coronary Insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arterio Sclerotic C.V. Disease
DUE TO (c) Arterio Sclerotic C.V. Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 yrs
10 yrs | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 2-10 , 19 57 , to 2-11 , 19 67 , that (I) (we) last saw the deceased alive on 2-10 19 67 , and that death occurred at 9 A.M. from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE Herbert Mueller Jr | | | | | 22b. DATE SIGNED 2-11-67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Herbert Mueller | | | | | 22d. ADDRESS Parkton, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE THEREOF 2/13/67 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | | | | |
| 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR FEB 14 1967 | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Jones | | | | |

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2082.7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div> <div>Item 2 See birth cert.</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01784</div> <div>CERTIFICATE OF DEATH</div> <div>01780</div> </div> | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | | | | |
| b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | | | | c. LENGTH OF STAY IN 1b
2 Days | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
St. Joseph | | | | | | d. STREET ADDRESS
1022 Woodson Road
7620 York Rd. | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Jane Renee Divine | | | | | | 4. DATE OF DEATH
Month Day Year
Feb. 21 19 67 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1/2/67 | | 9. AGE (In years last birthday)
yrs. 1 Months 21 Days 21 Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NONE | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 13. FATHER'S NAME
John Divine | | | | | | 14. MOTHER'S MAIDEN NAME
DORA DODSON | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | | | | 16. SOCIAL SECURITY NO.
— | | 17. INFORMANT
Parents | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7545
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Jose A. Aguirre | | | | | | 22b. DATE SIGNED
2-21-67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
2/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. JOHNS SWEET AIR | | | | 23d. LOCATION (City, town or county) (State)
SWEET AIR, MARYLAND | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd 21214 | | | | | | 25a. REC'D BY REGISTRAR
FEB 23 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|------------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| 56 <u>GREATER BALTO MED CENTER</u> | | | | <u>3133 E. MONUMENT ST</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>EVELYN ELIZABETH DORMAN</u> | | | | 4. DATE OF DEATH Month Day Year
<u>2-14-1967</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>SEP 29 1914</u> | 9. AGE (In years lost birthday)
<u>52</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Trading Stamp Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>BALTIMORE MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>EUGENE MONROE REINOLLAR</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>CATHERINE ELIZABETH HINAT</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u>080037024</u> | | 17. INFORMANT Address
<u>Mrs. Gay Carls, 813 1/2 Burnside, Hyattsville Md</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u>
<u>1992</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA, SITE?</u>
DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-24-67</u> , 1967, to <u>2/14/</u> , 1967, that (I) (we) last saw the deceased alive on <u>2/14/</u> 1967, and that death occurred at <u>1:15 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Arnold L. Field</u> | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/14/67.</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ARNOLD L. FIELD, M.D.</u> | | | 22d. ADDRESS
<u>901 Cathedral H Balto, Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/17/67.</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Memorial Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 16 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01781

01782

CARDIO RESPIRATORY FAILURE

82510

328

0100111101

544

Half a dozen

born on island?

5.2.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|-----------------------|--|---|--|---|--|--|--|-----------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01787 | | | | | 01783 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY
Baltimore, Maryland | | | MARYLAND | | a. STATE
Maryland | | | b. COUNTY
Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b
4 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | | d. STREET ADDRESS
710 Walker Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Dulaney Towson Nursing and Convalescent | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
Mary L. Mary | | | First Home Middle Last
Lillie Dunaway | | 4. DATE OF DEATH
2/12/67 | | Month 2 Day 12 Year 1967 | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/26/1888 | | 9. AGE (In years last birthday)
78 yrs. | | 10. UNO 1 YEAR
Months Days Hours Min. | | 11. UNO 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tel. Operator | | | 10b. KIND OF BUSINESS OR INDUSTRY
C&P Tel. Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Lancaster Co. Va. | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
James P. Moore | | | 14. MOTHER'S MAIDEN NAME
Va. Smith Moore | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
None | | 17. INFIRMANT
Mrs. Leonard P. Patterson | | | Address
same address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardio-vascular disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| MEDICAL CERTIFICATION
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 1966, to February 12, 1967, that (I) (we) last saw the deceased alive on February 9, 1967, and that death occurred at 8:10 a.m. from the causes and on the date stated above.
22a. SIGNATURE
A. Allan Smith
22b. DATE SIGNED
2/12/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal
23b. DATE THEREOF
2/13/1967
23c. NAME OF CEMETERY OR CREMATORY
Bethel Methodist Cemetery
23d. LOCATION (City, town or county) (State)
Lively, Va.
24. FUNERAL DIRECTOR
Wm. J. Tinkner & Son
25a. REC'D BY REGISTRAR
Baltimore, Md.
25b. REGISTRAR'S SIGNATURE
Charles Judge
DATE
FEB 14 1967 | | | | | | | | | |

01783

01783

4-7-68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01788

01784

FOR STATE HEALTH DEPT.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Balto MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md. b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | c. LENGTH OF STAY IN TB
1 life | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Parkville | | d. STREET ADDRESS
8609 Wendel ave. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hosp. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle J Last DURNER | | 4. DATE OF DEATH
Month Feb Day 7 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 29 1905 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR
Months 03 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer | | 10b. KIND OF BUSINESS OR INDUSTRY
20th Cen Press | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Durner | | 14. MOTHER'S MAIDEN NAME
Margaret Mueller | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-01-7024 | |
| 17. INFORMANT
Family records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) By pericarditis DUE TO (c) Sudden | | INTERVAL BETWEEN ONSET AND DEATH
59+ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Charles F. O'Donnell M.D. | | 22. DATE SIGNED
2/7/67 | |
| EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem | 23d. LOCATION (City or Town) (County) (State)
Balto Md. |
| 24. FUNERAL DIRECTOR
C.F. EVANS & SON 8802 Harford road | | 25a. REC'D BY REGISTRAR
FEB 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01734

01734

Bartholme
1175
J. Jussive Moss.
1175

June 2 1957
June 2 1957
June 2 1957

Printer
John Hunter
1175
Family records

Joseph O'Connell
John O'Connell

John O'Connell

4/1/57

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01789

CERTIFICATE OF DEATH

01785

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Towson | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21205 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | d. STREET ADDRESS
3108 McEldry Street | | |
| 3. NAME OF DECEASED (Type or print)
First Wallace Middle William Last Eckert | | | 4. DATE OF DEATH
Month February Day 5 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
January 7, 1893 | | 9. AGE (In years last birthday)
74 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tool Maker | | 10b. KIND OF BUSINESS OR INDUSTRY
City of Balto. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 13. FATHER'S NAME
unknown | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO.
220-03-3569 | | 17. INFORMANT
J. Claire Hewitt Eckert, wife, above |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular insufficiency
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma of lung | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Juan G. Gan</i> | | | 22b. DATE SIGNED
2-5-1967 | | 22c. PHYSICIAN'S NAME (Type)
Juan G. Gan, M. D. |
| 22d. ADDRESS
6720 York Road, Towson 4, Md. | | | 22e. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/8/67 | 23c. NAME OF CEMETERY OR CREMATORY
Baust United Church Cem. | | 23d. LOCATION (City or Town) (County) (State)
Tyrone, Md. |
| 24. FUNERAL HOME
Schlimmek Funeral Home, Inc. | | | 25a. REC'D BY REGISTRAR
DATE FEB 7 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Jones</i> |
| 2601 E. Madison St. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

08510

01525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01790

CERTIFICATE OF DEATH

01786

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
Baltimore 21220 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
1829 Wilson Point Rd. | |
| 3. NAME OF DECEASED (Type or print)
First John Middle E. Last EIMER SR. | | 4. DATE OF DEATH
Month February Day 23 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 2, 1920 |
| 9. AGE (In years last birthday) 46 yrs. | | 10. IF UNDER 1 YEAR
Months 46 Days 46 Hours 46 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Auto SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
CLARENCE W. | | 14. MOTHER'S MAIDEN NAME
MILLIE RUDOLPH | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
213-18-3684 | |
| 17. INFORMANT
CYNTHIA EIMER | | Address
ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 237X Brain tumor
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/17/1967 , to 2/23/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/23/1967 , and that death occurred at 1 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Regalado T. Dizon | | 22b. DATE SIGNED
February 23, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Regalado T. Dizon, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/27/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION (City or Town) (County) (State)
BALTO MD. | |
| 24. FUNERAL DIRECTOR
J.E. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
300 MACE | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | DATE
FEB 28 1967 | |

01586

00510

1287 8 11 133

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01791

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01787

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Golden Ring Rural | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Golden Ring Rural | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
8313 Allison Lane | | | | d. STREET ADDRESS
8313 Allison Lane off Kenwood Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First MARTIN Middle HENRY Last ELLIGSON | | | | 4. DATE OF DEATH
Month February Day 1 Year 1967 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-7-1907 | | | |
| 9. AGE (In years last birthday)
60 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY
Armco | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | |
| 13. FATHER'S NAME
William P. Elligson | | | | 14. MOTHER'S MAIDEN NAME
Barbara Lightner | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
212-05-7631 | | 17. INFORMANT
Mrs Elsie L. Elligson | | | | |
| | | | Address 8318 Allison Lane | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Contact Gunshot Wound of Head
976X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
App. Shot self. | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 2 p.m. 1 1967 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Basement | | 20f. (City or town) (County) (State)
Baltimore Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
Rudiger Breiteneker | | | M.D.
Rudiger Breiteneker, M.D. | | | 22. DATE SIGNED
2/2/67 | | | |
| EXAMINER'S NAME (Type) | | | Address (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-4-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home 7401 Belair Road | | | | ADDRESS
36 | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| | | | | DATE
FEB 6 1967 | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
items 11, 12 Film G386 3/3/67 mh
01792
CERTIFICATE OF DEATH
01788

| | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Essex | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1215 Homberg Avenue - 21221 | | | | d. STREET ADDRESS
1215 Homberg Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Daisy Middle May Last Elza | | | | 4. DATE OF DEATH
Month Feb. Day 18 Year 19 67 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-26-09 | | | |
| 9. AGE (In years lost birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Bowden, West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Earl Arbogast | | | | 14. MOTHER'S MAIDEN NAME
Mary - | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO.
234-44-4843 | | 17. INFORMANT
Mrs. Bernice Rowan-205 Linwood Ave-21224 | | | Address Balto., Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory failure
1992 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the gall bladder and liver
DUE TO (c) (Exploratory laparotomy in January, 1967) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
few hours
2 months | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
none | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/10 , 19 67 , to 2/18 , 19 67 , that (I) (we) last saw the deceased alive on 2/18 , 19 67 , and that death occurred at 10:30 P, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Eugene C. Baumann | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-19-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Eugene C. Baumann | | | | 22d. ADDRESS
413 Eastern Avenue, Balto., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-22-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Odd Fellows Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Elkins, West Virginia | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard-4107 Wilkens Ave. Balto., Md. | | | | ADDRESS
21229 | | 25a. REC'D BY REGISTRAR
EB 24 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|------------------|-------------------------|--|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01793 | | | | | 01789 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY | | BALTIMORE | | | a. STATE | | MARYLAND | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | TOWSON | | | b. COUNTY | | BALTIMORE | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | |
| GREATER Baltimore Medical Center | | | | | 8206 TAMA CT. | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First Middle Last | | | | | Month Day Year | | | | |
| JEROME None ENGEL | | | | | February 8 1967 | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | |
| MALE | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | JAN 8 1915 | | 52 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Plastic Products | | | | ENGEL | | BALTIMORE MONTGOMERY MD. | | U.S.A. | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Executive LOUIS ENGEL | | | | | Reba FRIEDENBERG | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 217-05-8166 | | Mrs. Elaine Engel, 8206 Tama Court #8 | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | 12 Days | |
| IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA | | | | | | | | 8 YEARS | |
| 204.0 DUE TO | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO | | | | | | | | | |
| LYMPHOCYTIC LEUKEMIA | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| Hour a.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| 21. I certify that (this hospital) attended the deceased from Jan 31, 1967, to Feb 8, 1967, that (we) last saw the deceased alive on Feb 8, 1967, and that death occurred at 9:45 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE | | | | | | 22b. DATE SIGNED | | | |
| T.C. Cullis MD | | | | | | Feb 8, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | |
| T. C. CULLIS | | | | | | Greater Baltimore Medical Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | |
| Burial | | | 2/9/67 | | Aitz Chaim | | Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Sol Levinson & Bros. Inc., 6010 Reisterstown | | | | | | DATE FEB 14 1967 | | Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #G386 3/15/67 pc

01794

CERTIFICATE OF DEATH

01790

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. LENGTH OF STAY IN 1b
21220 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Ridgeway Manor Nursing Home | | | | d. STREET ADDRESS
5743 Diamondson Avenue | | | |
| 3. NAME OF DECEASED
(Type or print)
First Ada Middle L. Last Fair | | | | 4. DATE OF DEATH
Month 2 Day 27 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-23-1874 | | 9. AGE (In years last birthday)
92 yrs. | 10. IF UNDER 1 YEAR
Months 1 Days 3 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
285-34-7439A | | 17. INFORMANT
Mr Otto Egner Chase P.O. Chase, Md. 21227 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day and | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Jan , 19 66 , to 27 , 19 67 , that (I) (we) last saw the deceased alive on 27 Feb 19 67 , and that death occurred at 1030 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
William Goodman | | | | 22b. DATE SIGNED
Mar 1, 67 | | 22c. PHYSICIAN'S NAME (Type)
WILLIAM GOODMAN MD | |
| 22d. ADDRESS
1334 Sycamore Spring Road | | | | 22e. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-2-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Grand View Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Chillicothe Ohio | |
| 24. FUNERAL DIRECTOR
Lessa Funeral Home 7401 Belair Road | | | | 25. REC'D BY REGISTRAR
6 MAR 6 1967 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01795

CERTIFICATE OF DEATH

01791

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
21204 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1644 Hardwick Road | | d. STREET ADDRESS
1644 Hardwick Road | |
| 3. NAME OF DECEASED (Type or print)
GEORGE JOSEPH FAUSTMAN
First Middle Last | | 4. DATE OF DEATH
February 27 1967
Month Day Year | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 21, 1914 |
| 9. AGE (In years last birthday)
53 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Luggage manager | | 10b. KIND OF BUSINESS OR INDUSTRY
Korvette Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William F. Faustman | | 14. MOTHER'S MAIDEN NAME
Anna Grandy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW 2 | | 16. SOCIAL SECURITY NO.
213-05-7382 | |
| 17. INFORMANT
Mrs. Mary Read Faustman, 1644 Hardwick Rd., 4 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4201 DUE TO Coronary thrombosis, probable
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) History of acute Pulmonary edema
(c) probably due to Coronary Insufficiency | | INTERVAL BETWEEN ONSET AND DEATH
minutes
3 1/2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from October 1963 , to February 1967 , that (I) (we) lost the deceased alive on Feb. 15 1967 , and that death occurred at 14 M, from causes on the date stated above. | | | |
| 22a. SIGNATURE
William P. Benson, Jr. | | 22b. DATE SIGNED
2-27-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. William P. Benson, Jr. | | 22d. ADDRESS
3506 N. Calvert St., Balto., 18 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
3/2/67. | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.--Baltimore, Md.--14 | | 25a. REC'D BY REGISTRAR
FEB 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

10310

01231

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01796 CERTIFICATE OF DEATH 01792

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MD b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
600 STONEY LANE | | d. STREET ADDRESS
600 STONEY LANE | |
| 3. NAME OF DECEASED (Type or print)
First FRANCIS Middle P. Last FAYA | | 4. DATE OF DEATH
Month FEB. Day 17 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 29 1884 |
| 9. AGE (In years last birthday)
82 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (County & State, or foreign country)
MD | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HERMAN FAYA | | 14. MOTHER'S MAIDEN NAME
MARY HOLTMAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
WALTER P. FAYA | | Address
600 1/2 STONEY LANE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.D.
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.I.-C.V.D.
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
28 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
No other conditions | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 65 , to 2-17 , 19 67 , that (I) (we) last saw the deceased alive on 2-17-67 , and that death occurred at 6 P.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
James E. Howald | | 22b. DATE SIGNED
2-18-68 | |
| 22c. PHYSICIAN'S NAME (Type)
1011 Frederick Rd - 28 | | 22d. ADDRESS
1011 Frederick Rd - 28 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/20/67 | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL | 23d. LOCATION (City, town or county) (State)
BALTIMORE 28, MD. |
| 24. FUNERAL DIRECTOR
FARLEY-CAVANAUGH | | 25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| ADDRESS
6601 FREDERICK AVE. | | DATE
FEB 20 1967 | |

01320

01320

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01797

CERTIFICATE OF DEATH

01793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> b. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | | c. LENGTH OF STAY IN 1b
<u>GREENBELT</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>PARADISE NURSING HOME</u> | | | | d. STREET ADDRESS
<u>PARKWAY</u> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>JOHN RAYMOND FEREY</u> | | | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>5</u> Year <u>1967</u> | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>CAUCASIAN</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>30 JAN 1887</u> | |
| | | | | 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SALESMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>REAL ESTATE</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>N. DAKOTA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>JOHN HENRY FUREY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>397-01-6209</u> | | 17. INFORMANT
<u>BENTRICE E. FUREY</u> | | Address <u>P.O. Box 123 GREENBELT, MARYLAND</u> | |
| 18. CAUSE OF DEATH (Enter only one cause, prevailing for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis Right Hemisphere</u>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>
DUE TO (c) <u>Chronic Pain Syndrome</u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs.</u>
<u>10 yrs.</u>
<u>10 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 2Dc. TIME OF INJURY
Month, Day, Year
Hour <u>19</u> e.m. p.m. | | 2Dd. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 2Df. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/5/67</u> to <u>2/5/67</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>2/5/67</u> , and that death occurred <u>11:28 AM</u> on the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. E. McGrath M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. E. McGrath M.D.</u> | | | | 22d. ADDRESS
<u>1303 Frederick Rd Catonsville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>8-FEB-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Joseph's Cem.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Beltsville, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>W. W. Chambers Co. Riverdale, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>FEB 10 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01330

01331

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MAR 11

MAR 11 1961

MAR 11 1961

MAR 11 1961

MAR 11 1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01794

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>St. Joseph's Hospital</u> | | d. STREET ADDRESS
<u>Washington Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>John J.</u> Middle <u>Fielding</u> Last <u></u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 25, 1889</u> |
| 9. AGE (In years last birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter - Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self Employed</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Daniel J. Fielding</u> | | 14. MOTHER'S MAIDEN NAME
<u>Laura J. Fielding</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>217-09-3445</u> | |
| 17. INFORMANT
<u>Family Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u>
DUE TO <u>Coronary Occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Coronary Insufficiency</u>
(b) <u></u>
DUE TO <u></u>
(c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>Charles F. O'Donnell</u>
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u> | | 22. DATE SIGNED
<u>2/7/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 10, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Maria Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Towson, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 10 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

01384

01384

01384



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01799

01795

| | | | | | | | |
|--|--|--|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | | c. LENGTH OF STAY IN 1b
14 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore, Md. 21234 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
9606 Harding Avenue | | | | d. STREET ADDRESS
9606 Harding Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Walter Middle Levi Last Finch | | | | 4. DATE OF DEATH
Month February Day 10 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 18, 1881 | |
| 9. AGE (In years last birthday)
85 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Assembly | | 10b. KIND OF BUSINESS OR INDUSTRY
Instrument | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
George Finch | | | |
| 14. MOTHER'S MAIDEN NAME
Ruth Janes | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO.
213-09-2267 | | | | 17. INFORMANT
Mrs. LaVerne E. Doerer | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
1992 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Arteriosclerotic cardiovascular disease DUE TO
(c) Carcinomatosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden

Several yrs.

Approx. 1 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (we) attended the deceased from July 6, 1960 to Feb. 6, 1967 , that (I) (we) lost the deceased alive on Feb. 6, 1967 , and that death occurred at 7:15 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>S.J. Liu</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
Feb. 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
S.J. Liu, M.D. | | | | 22d. ADDRESS
5301 Harford Road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/13/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co., Md. | |
| 24. FUNERAL DIRECTOR
<i>William E. Johns</i> | | | | ADDRESS
8521 Loch Raven B'lv. | | 25a. REC'D BY REGISTRAR
DATE FEB 15 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01335

CENTRAL DE BATA

01335

Baltimore

Baltimore

Baltimore

Baltimore, Md.

Baltimore

Baltimore, Md.

3000 Barclay Avenue

3000 Barclay Avenue

1937

1937

1937

1937

White

White

Instrument

Assembly

Baltimore, Md.

George T. Simon

George T. Simon

1937-1938

1937

1937-1938

1937-1938

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1937-1938

1937-1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01800

CERTIFICATE OF DEATH

01796

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN 1b
Years | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | d. STREET ADDRESS
814 Hathleigh Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
814 Hathleigh Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First ROBERT Middle S. Last FISHER | | 4. DATE OF DEATH
Month February Day 23. Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 8, 1908 |
| 9. AGE (In years lost birthday)
58 yrs. | | IF UNDER 1 YEAR
Months 23 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
Vice Pres. & Treas. | | 10b. KIND OF BUSINESS OR INDUSTRY
Dairy | |
| 11. BIRTHPLACE (County & State, or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edgar C. Fisher | | 14. MOTHER'S MAIDEN NAME
Irene K. Schaeffing | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-03-2416 | |
| 17. INFORMANT
Mrs. Ricka Fisher, Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 23 1 5 00 AM | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1936 , 19 67 , to 2/23 , 19 67 , that (I) (we) last saw the deceased alive on Feb 16 , 19 67 , and that death occurred at 7A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Walter E. Karfman | | 22b. DATE SIGNED
2/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
WALTER E. KARFMAN MD | | 22d. ADDRESS
4331 Harford Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Feb. 25, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland | | 25a. REC'D BY REGISTRAR
FEB 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01380

CERTIFICATE OF DEATH

01800

FEB 28 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01801

CERTIFICATE OF DEATH

01797

| | | | | | |
|--|-------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>
c. LENGTH OF STAY IN lb <i>3 weeks</i>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Chapel Hill Convalescence Home</i> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Howard</i>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i> <i>13-2</i>
d. STREET ADDRESS <i>Waterloo Rd.</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) <i>Artie Emma Fitzwater</i> | | | 4. DATE OF DEATH
Month <i>Feb.</i> Day <i>26</i> Year <i>1967</i> | | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>12-24-1893</i> | 9. AGE (In years last birthday) <i>73</i> yrs.
IF UNDER 1 YEAR: Months <i>2</i> Days <i>1</i> Hours <i>1</i> Min. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> |
| 11. BIRTHPLACE (County & State, or foreign country)
<i>Keyser W. Virginia</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U-S</i> | | |
| 13. FATHER'S NAME
<i>Carl Lough</i> | | | 14. MOTHER'S MAIDEN NAME
<i>Emma Collier</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) <i>None</i> | | | 16. SOCIAL SECURITY NO.
<i>None</i> | | |
| 17. INFORMANT
<i>daughter Esther Turner</i> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Septicemic shock</i>
DUE TO (b) <i>Acute urinary infection</i>
(c) <i>Anteriosclerotic cardio vascular disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2-26-1967</i> , to <i>2-26-1967</i> , that (I) (we) last saw the deceased alive on <i>2-26-1967</i> , and that death occurred at <i>4:12 PM</i> , from the causes and on the date stated above. | | | 22a. SIGNATURE
<i>Dr. Barbu Calin</i> M.D. | | |
| 22b. DATE SIGNED
<i>2-26-67</i> | | | 22c. PHYSICIAN'S NAME (Type)
<i>Dr. BARBU CALIN</i> | | |
| 22d. ADDRESS
<i>8811 Liberty Rd. Randallstown Md.</i> | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | |
| 23b. DATE THEREOF
<i>3-1-1967</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Meadowridge Cemetery</i> | | |
| 23d. LOCATION (City, town or county)
<i>Howard County, Maryland</i> | | | 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Ellsworth Armacost</i> | | |
| 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

01331

01801

11

138

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01798

| | | | |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Conn. b. COUNTY Greenwich | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rowson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Greenwich | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
772 North St. | |
| 3. NAME OF DECEASED
(Type or print) Lisa First FLINN Middle FLynn Last FLynn | | 4. DATE OF DEATH
Month FEB Day 2 Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
APR. 7 1949 |
| 9. AGE (In years lost birthday) 17 yrs. | | 10. IF UNDER 1 YEAR
Months 1 Days 17 Hours 17 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SCHOOL GIRL | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
CONN. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
GEORGE H FLINN JR | | 14. MOTHER'S MAIDEN NAME
EVELYN LILLEY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT
EVELYN FLINN | | Address
ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) IRREVERSIBLE BRAIN DAMAGE
845X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SUBARACHNOID AND SUBDURAL HEMORRHAGE
DUE TO (c) --- | | | INTERVAL BETWEEN ONSET AND DEATH
4 DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
FELL OFF HORSE | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. JAN 30 1967 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
SCHOOL | | 20f. (City or town) GLENDEN (County) BALTO. (State) MD. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William A. Pillsbury M.D. | | 22. DATE SIGNED 2-2-67 | |
| EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | 23b. DATE THEREOF
2/3/67 | 23c. NAME OF CEMETERY OR CREMATORY
PITTSBURG | 23d. LOCATION (City or Town) (County) (State)
PITTSBURG PT |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | 25a. REC'D BY REGISTRAR
DATE 5 6 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01803

CERTIFICATE OF DEATH

01799

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River | | | | c. LENGTH OF STAY IN 1b
03-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Ivy Hall Nursing Home | | | | d. STREET ADDRESS
Box 455 Burke Road Bowleys Qtrs | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Foot Last Foot | | | | 4. DATE OF DEATH
Month 2 Day 25 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-4-1895 | | 9. AGE (In years last birthday)
71 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
Zachirah Foot | | | | 14. MOTHER'S MAIDEN NAME
Annie Burkhart | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-07-2216 | | 17. INFORMANT
Address #4 Mrs Jeanette Fanning 318 Worthington Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Circulatory failure
177X DUE TO Cancer of the esophagus (metastasis)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the prostate gland
(c) Suppurative Cardiovascular disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 weeks
9 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Suppurative Cardiovascular disease | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. — p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/15/63 , 1963, to 2/24 , 1967, that (I) (we) lost the deceased on 2/24 , 1967, and that death occurred at 2 A M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Eugene C. Baumann M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-27-67 | |
| 22c. PHYSICIAN'S NAME (Type)
EUGENE C. BAUMANN | | | | 22d. ADDRESS
413 EASTERN AVE Baltimore 21. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-28-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Bel Air Memorial Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Bel Air Md. | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | | | 25a. REC'D BY REGISTRAR
FEE 28 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01804

01800

| | | | | | | | |
|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) BALTIMORE</u>
c. LENGTH OF STAY IN 1b <u>52 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MT. VISTA RD.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(RURAL) BALTIMORE</u>
d. STREET ADDRESS <u>MT. VISTA RD</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>LEONARD MORRIS FORD</u> | | | 4. DATE OF DEATH
Month Day Year
<u>2 - 8 1967</u> | | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/19/14</u> | 9. AGE (In years last birthday)
<u>52 yrs.</u> | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>STANDARDS CONTROL AIRCRAFT</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>HARFORD CO., MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>BARTLETT FORD</u> | | | 14. MOTHER'S MAIDEN NAME
<u>IDA M. SHANE</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>259-09-4532</u> | 17. INFORMANT Address
<u>ANTOINETTE FORD MT. VISTA RD. BALTO. CO. MD.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u>
DUE TO (b) <u>METASTATIC SARCOMA</u>
DUE TO (c) <u>1992</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 mos.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>11/22</u> , 19 <u>67</u> , to <u>2/8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>67</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Miles E. St. John, MD</u> | | | 22b. DATE SIGNED
<u>2/8/67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MILES E. ST. JOHN, MD.</u> | | | 22d. ADDRESS
<u>9660 BELAIR RD. BALTO., MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2-11-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Michael's Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Ferry Hall, Baltimore Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Lassahn Funeral Home 7401 Belair Road 36</u> | | | 25a. REC'D BY REGISTRAR
<u>FEB 14 1967</u>
25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

45310

INDEX

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G386 2/24/67 mh

01805

CERTIFICATE OF DEATH

01801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Cockeysville, Towson MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cockeysville | | c. LENGTH OF STAY IN 1b
2 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Masonic Homes Cockeysville | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First THOMAS Middle D Last FRANKLIN | | 4. DATE OF DEATH
Month FEBRUARY Day 14 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan, 14, 1887 |
| 9. AGE (In years lost birthday)
80 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SILVER SMITH | |
| 11. BIRTHPLACE (County & State, or foreign country)
North Attleboro, Mass. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John P. Franklin | | 14. MOTHER'S MAIDEN NAME
Laura Thompson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-07-6134 | |
| 17. INFORMANT
Masonic Homes Cockeysville, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 arteriosclerotic heart disease
DUE TO (c) 3 Aspiration pneumonia | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August , 19 65 , to Feb 14 , 19 67 , that (I) (we) last saw the deceased alive on Feb 13 , 19 67 , and that death occurred at 6:50 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
James H. Hamed M.D. | | 22b. DATE SIGNED
FEB 14, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
JAMES H. HAMED | | 22d. ADDRESS
MASONIC HOMES | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/17/67 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Cemetery | 23d. LOCATION (City or Town) (County) (State)
Elkridge, Maryland |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | 25a. REC'D. BY REGISTRAR
Feb 20 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

01806

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01802

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
31yr29dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Virginia Last Lee | | 4. DATE OF DEATH
Month Feb. Day 23 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. B. DATE OF BIRTH
8-5-88 |
| 9. AGE (In years last birthday)
78 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James A. Richardson | | 14. MOTHER'S MAIDEN NAME
Virginia Grinder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-54-3115T | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute bilateral pneumonia
490X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pulmonary disease
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
Chronic brain syndrome associated with cerebral arterio. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-24-36 , 19__, to 2-23 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-23-67 , 19__, and that death occurred at 6:50 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Evelio A. Felipe</i> | | 22b. DATE SIGNED
2-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Evelio A. Felipe | | 22d. ADDRESS
Spring Grove State Hospital
Catonsville, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3-1-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Old Federal Road Baltimore | |
| 24. FUNERAL DIRECTOR
Krause Funeral Home 12165 Charles St | | 25a. REC'D BY REGISTRAR
DATE MAR 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01807

CERTIFICATE OF DEATH

01803

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
50 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
PIKESVILLE | |
| f. STREET ADDRESS
739 HOWARD ROAD | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle JOSEPH Last FREEMAN | | 4. DATE OF DEATH
Month FEBRUARY Day 2 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEBRUARY 6, 1900 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
AUTOMOBILE | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SAMUEL BROWN FREEMAN | | 14. MOTHER'S MAIDEN NAME
MARY ELIZABETH KIRWIN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
212 01 77 80 | |
| 17. INFORMANT
VA HOSPITAL | | 18. CLINICAL RECORDS
FORT HOWARD, MARYLAND | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5811 LAENNEC'S CIRRHOSIS OF LIVER
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from DEC. 11, 19 66 , to FEB 2, 19 67 that (2) (we) last saw the deceased alive on FEB 2, 19 67 , and that death occurred at 1110PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John D. Talbert | | 22b. DATE SIGNED
2/3/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
Feb. 6, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE, NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
FRANK H. NEWELL INC. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 26. DATE
FEB 6 1967 | |
| REISTERSTOWN RD & WALDRON AVE, PIKESVILLE, MD. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------|-------------------|--|------------------------------------|---|--|--|---|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01808 | | | | | | 01804 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY | | | BALTIMORE | | | a. STATE | | | MARYLAND | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | SPARKS | | | b. COUNTY | | | BALTO. | | |
| c. LENGTH OF STAY IN 1b | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | SPARKS | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? | | |
| SPARKS ROAD | | | | | | SPARKS ROAD | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| FREDERICK | | | D. FRUTCHY | | | FEB. | | | 25 1967 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | MAR. 26, 1907 | | 59 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| BOOK-KEEPER | | | | WOLF & MANN CO. | | NEW JERSEY | | | USA | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| MARQUIS P. FRUTCHY | | | | | | MARIE DOUBMAN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | | NONE | | 143-01-4921 | | FAMILY RECORDS | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hemorrhage - Esophageal Varices | | | | | | | | | | 1 yr | |
| 5810 DUE TO (b) Cirrhosis of Liver | | | | | | | | | | 6-10 yr | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| Hour a.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-24, 1967, to 2-25, 1967, that (I) (we) last saw the deceased alive on 2-25 1967, and that death occurred at 9 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | 22b. DATE SIGNED | | | |
| C. Herbert Mueller | | | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 2-25-67 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | | | | | |
| C. HERBERT MUELLER JR. | | | | PARKTON MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | | | |
| CREMATION | | | FEB. 27, 1967 | | GREENMOUNT CEM. | | | BALTIMORE, MD. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John Burns Son's | | | | Johnson Md. | | | | DATE MAR 2 1967 | | | |
| | | | | | | | | John Charles Judge | | | |

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MAR 2 1961

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01805

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | c. LENGTH OF STAY IN lb
Woodlawn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Baltimore County General Hospital | | d. STREET ADDRESS
6725 Kincheloe Ave. | |
| 3. NAME OF DECEASED
(Type or print)
First John Middle M. Last Fuller | | 4. DATE OF DEATH
Month Feb. Day 26 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-2-97 |
| 9. AGE (In years last birthday) yrs
69 | | IF UNDER 1 YEAR
Months 03-1 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tile (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore, Md. | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Fuller | | 14. MOTHER'S MAIDEN NAME
Genevieve Maisel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) yes (If yes give war or dates of service) WW I | | 16. SOCIAL SECURITY NO.
714-05-6755A | |
| 17. INFORMANT
Thos. Fuller-6725 Kincheloe Ave., Woodlawn, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured aortic aneurysm - Thoracic
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 hrs.
3 hrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples M.D. | | 22. DATE SIGNED 2-27-67 | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | 6 Hanover Rd. Baltimore, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/1/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
DATE MAR 3 1967 | |
| ADDRESS
4107 Wilkens Ave. | | 25b. REGISTRAR'S SIGNATURE
J. Charles J. J. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01810 | | | | | CERTIFICATE OF DEATH | | | 01806 | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY - | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | | c. LENGTH OF STAY IN 1b
60 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | | d. STREET ADDRESS
1380 NORTH CALHOUN STREET | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First CHARLES Middle WILLIAM Last HENDERSON GASKINS | | | | | 4. DATE OF DEATH
Month FEBRUARY Day 6 Year 1967 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 5, 1909 | | 9. AGE (In years lost birthday)
57 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
LOTTESBURG, VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOSEPH GASKINS | | | | | 14. MOTHER'S MAIDEN NAME
LIZA KING | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | | | 16. SOCIAL SECURITY NO.
215 46 89 42 | | 17. INFORMANT
VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INFARCTION OF MYOCARDIUM, ACUTE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC CORONARY THROMBOSIS, ACUTE
(c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
NEOPLASM METASTATIC, HEAD & NECK OF LEFT FEMUR, PRIMARY SITE UNKNOWN.
GOITR. PYELONEPHRITIS, CHRONIC | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that W (this hospital) attended the deceased from DEC. 8 , 19 66 , to FEB. 6 , 19 67 , that W (we) last saw the deceased alive on FEB 6 , 19 67 , and that death occurred at 1110P , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
George Dudas | | | | 22b. DATE SIGNED
2/7/67 | | 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, M. D. | | | |
| 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE THEREOF
2-13-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
George Nelson | | | | 24a. ADDRESS
KELSON FUNERAL HOME | | 25a. REC'D BY REGISTRAR
10 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| | | | | 24b. ADDRESS
N. CALHOUN ST. BALTIMORE, MD. | | | | | |

01800

REPORT OF DEATH

01870

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|
| 01811
1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 2 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home | | | | | 01801
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY CARROLL Frederick ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminister
d. STREET ADDRESS 18 Webster Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Ada First Rebecca Middle Gaver Last | | | 4. DATE OF DEATH Feb. 11 Month 11 Day 19 Year 67 | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/30/1886 | | 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 80 Days 80 Hours 80 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) FREDERICK, MD. | | 12. CITIZEN OF WHAT COUNTRY? U-S-A. | | |
| 13. FATHER'S NAME Tyson D. Dubel | | | | | 14. MOTHER'S MAIDEN NAME Amanda C. | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Glayds S. Latimer Address Ellicott City, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not White <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-23 , 19 67 , to 2-11 , 19 67 , that (II) (we) last saw the deceased alive on 2-10 , 19 67 , and that death occurred at 10 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Thomas F. Herbert M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2-11-67 | | |
| 22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D. | | | | | 22d. ADDRESS 44 Chandler Ellicott City, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/14/67 | | 23c. NAME OF CEMETERY OR CREMATORY ST. PAUL'S LUTH. CEMETERY | | 23d. LOCATION (City, town or county) (State) MYERSVILLE MD. | | | |
| 24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md. ADDRESS | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |
| | | | | | DATE FEB 15 1967 | | | | |

MEDICAL CERTIFICATION

50810

1120

FOR STATE
HEALTH DEPT.

01812

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01808

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Balto.</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Md.</i> b. COUNTY <i>City.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Int. Wilson, Md.</i> | | c. LENGTH OF STAY IN ^{1b}
<i>3-5 mn.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Int. Wilson State Hosp.</i> | | d. STREET ADDRESS
<i>2001 Hargrove St.</i> | |
| 3. NAME OF DECEASED (Type or print) <i>CLARENCE SAVAGE GIBSON</i> | | 4. DATE OF DEATH Month <i>Feb</i> Day <i>19</i> Year <i>1967</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>colored</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>4-14-'14</i> |
| 9. AGE (In years last birthday) <i>52</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>fruit market (Cahoon) Ind.</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Missouri</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i> | |
| 13. FATHER'S NAME
<i>Howard Gibson</i> | | 14. MOTHER'S MAIDEN NAME
<i>Missouri Savage</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i> | | 16. SOCIAL SECURITY NO. <i>216-09-3106</i> | |
| 17. INFORMANT Address
<i>Int. Wilson Records - Int. Wilson, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cor-Pulmonale</i>
<i>002.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>For Advanced Pulmonary Tbc.</i>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 mt.</i>
<i>4 1/2 yrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>None.</i> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> <i>None.</i> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>none</i> p.m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <i>none</i> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>none</i> | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>D. D. Caples</i> | | 22. DATE SIGNED <i>2-19-67</i> | |
| EXAMINER'S NAME (Type) <i>D. D. CAPLES.</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | 23b. DATE THEREOF
<i>2-23-67</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Auburn Cem.</i> | 23d. LOCATION (City or Town) (County) (State)
<i>BALTO. Md.</i> |
| 24. FUNERAL DIRECTOR
<i>GEO. NELSON FUNERAL HOME 1348 CALHOUN ST</i> | | 25a. REC'D BY REGISTRAR
<i>Feb 21 1967</i> | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

20810

21810

FOR STATE HEALTH DEPT.

01813

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01809

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Randallstown | | | c. LENGTH OF STAY IN 1b
1 hr. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pikesville 8, Md. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Baltimore Co. General Hospital | | | | d. STREET ADDRESS 124 Slade Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harlan Middle Drake Last Gilkerson | | | | 4. DATE OF DEATH
Month 2 Day 18 Year 19 67 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
April 4, 1933 | | 9. AGE (In years last birthday)
33 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sanitation truck | | 10b. KIND OF BUSINESS OR INDUSTRY
Arthur Mosher | | 11. BIRTHPLACE (State or foreign country)
Prichard, West Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Burgess Gilkerson | | | | 14. MOTHER'S MAIDEN NAME
Virginia Perry | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
706-18-6427 | | 17. INFORMANT
Mrs. Agnes Wright, 124 Slade Ave., Pikesville 8. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning
891.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Acute alcoholic intoxication | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Inhalation of exhaust fumes from auto | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. ? p.m. 2 18 19 67 | | 20d. INJURY OCCURRED 2
While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Driveway | | 20f. (City or town) (County) (State)
Baltimore Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
2/19/67 | | | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb. 22, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Gilkerson Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Prichard, West Virginia | |
| 24. FUNERAL DIRECTOR
Frank H. Newell, Pikesville 8, Md. | | | | 25a. REC'D BY REGISTRAR
Feb 27 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

40810

51810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01814

CERTIFICATE OF DEATH

01810

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore #21234 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
2645 Wendover Rd. | |
| 3. NAME OF DECEASED (Type or print)
First Baby boy Middle Goedeke Last Goedeke | | 4. DATE OF DEATH
Month February Day 5 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Feb. 5, 1967 |
| 9. AGE (In years lost birthday) yrs.
17 | | IF UNDER 1 YEAR
Months 12 Days 17 Hours 17 Min. 17 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Paul Francis Goedeke | | 14. MOTHER'S MAIDEN NAME
French, Mrs. Joan Angela | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Parents | | Address
same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X Immaturity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 5, 1967 to Feb. 5, 1967 , that (I) (we) last saw the deceased alive on Feb. 5, 1967 , and that death occurred at 7:55 AM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Jose A. Aguto | | 22b. DATE SIGNED
Feb. 5 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Jose A. Aguto | | 22d. ADDRESS
6220 York Rd. Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
2-8-67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | 23d. LOCATION (City or town) (County) (State)
Balto Md |
| 24. FUNERAL DIRECTOR
CHAR. F. EVANS & Son | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| ADDRESS
8802 Harford Rd | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| DATE
FEB 16 1967 | | | |

01810

1840

FOR STATE
 HEALTH DEPT.

01815

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01811

| | | | | | | | |
|---|----------------------------------|---|---|---|---------------------------|--|---------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville-rural | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove Hospital | | | | d. STREET ADDRESS
7952 Riggs Rd. | | | |
| 3. NAME OF DECEASED (Type or print)
First Betty Middle C. Last Golden | | | | 4. DATE OF DEATH
Month 2 Day 17 Year 1967 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG 10, 1903 | 9. AGE (In years last birthday)
63 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | IF UNDER 24 HRS.
Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
RUSSIA | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
SAMUEL | | | |
| 14. MOTHER'S MAIDEN NAME
IDA LERNER | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
V15-09-1253 | | | | 17. INFORMANT
STANLEY GOLDEN | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Death during epileptic seizure
353.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| 22. DATE SIGNED
2/18/67 | | | | 23. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
2/19/67 | | 23c. LOCATION (City or Town) (County) (State)
Hyattsville, Mont. Md. | |
| 24. FUNERAL DIRECTOR
SYLVAN S. LEWIS + SON | | | | 25a. REC'D BY REGISTRAR
GARRISON, MD. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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01812

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01816 | | | | | | 01812 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) | | | | | |
| a. COUNTY
Baltimore | | | | | | a. STATE
Maryland | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Dulaney-Towson Nursing Home, 111 West Rd. | | | | | | d. STREET ADDRESS
5709 Winner Ave. 21215 | | | | | |
| 3. NAME OF DECEASED (Type or print)
WILLIAM GOODMAN | | | | | | 4. DATE OF DEATH
Month 2 Day 26 Year 1967 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/8/87 | | 9. AGE (In years last birthday)
79 yrs. | | 10. IF UNDER 1 YEAR
Months 26 Days 26 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retail | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Merchant | | 11. BIRTHPLACE (County & State, or foreign country)
Russia | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Morris Goodman | | | | | | 14. MOTHER'S MAIDEN NAME
Rebecca ? | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
219-32-1879 | | 17. INFORMANT
Mrs. Rebecca Goodman, 5709 Winner Avenue | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA
4200
DUE TO arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral thromboses | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/26 , 19 67 , to 2/26 , 19 67 , that (I) (we) last saw the deceased alive on 2/26 , 19 67 , and that death occurred at 4:00 PM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Leonard H. Golombek | | | | | | ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/26/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
LEONARD H. GOLOMBEK | | | | | | 22d. ADDRESS
Liberty Road | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/28/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Jacob | | | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Sol Levinson & Bros. Inc., 6010 Reist., Rd. | | | | | | 25a. REC'D BY REGISTRAR
MAR 6 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01817

CERTIFICATE OF DEATH

03212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------------------------|--|------------------------------------|
| 1. NAME OF DECEASED
(Type or Print)
MARY C. GORMAN | | 2. DATE AND HOUR OF DEATH
FEB. 28, 1967 9:10 A.M. | |
| 3. PLACE OF DEATH (Where deceased lived. If institution: residence before admission)
BALTIMORE COUNTY | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY 30-4 | |
| FULL NAME OF HOSPITAL OR INSTITUTION
ARMACOST NURSING HOME
812 REGESETER AVE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE | |
| D. STREET ADDRESS (If rural, give location)
MARYLANDER APTS. 3501 ST. PAUL S | | | |
| 5. SEX
FEMALE | 6. RACE
WHITE | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
SINGLE | 8. DATE OF BIRTH
5/23/35 |
| 9. AGE (In years last birthday)
31 | | 10. CITIZEN OF WHAT COUNTRY?
USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED REGISTERED NURSE | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | |
| 13. FATHER'S NAME
JOHN J. GORMAN | | 14. MOTHER'S MAIDEN NAME
JANE LALLY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MR. T. J. GROGAN, JR | | ADDRESS
929 N. HOWARD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Cancer of Breast | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs | |
| 19. ANTECEDENT CAUSES
(DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)
170X | | | |
| (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | |
| 22. I certify that (I) (this hospital) attended the deceased, from Feb 9 1967 to Feb 28 1967
that (I) (we) lost saw the deceased alive on Feb 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE
Dr. William G. Helberich | | 23B. DATE SIGNED
3-1-67 | |
| 23C. PHYSICIAN'S NAME (Type)
DR. WILLIAM G. HELBERICH | | 23D. ADDRESS
5006 ROLAND AVE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 24B. DATE
3/2/67 | |
| 24C. NAME of CEMETERY or CREMATORY
NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State)
BALTIMORE, MD | |
| 25A. DATE REC'D BY HEALTH DEPT.
MAR 7 1967 | | 25B. NAME OF REGISTRAR
Charles J. J... | |
| 25C. FUNERAL DIRECTOR
H.W. MEARS & SON | | ADDRESS
305 N. CALVERT S | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>843 Greenway</u> | | d. STREET ADDRESS <u>8432 Greenway Rd Apt D</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CLARENCE FREDERICK GRAESER</u> | | 4. DATE OF DEATH <u>Feb 8 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 24 1899</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Rep</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ind.</u> | |
| 13. FATHER'S NAME <u>George Trauser</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Mack</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-09-2363A</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Q. C. V. D.</u>
(a), stating the underlying cause last. (c) <u>(Arteriosclerotic Cardiovascular Dis)</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Non Resected Ca Bowel - 7 yrs post op. Colostomy</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>a.m.</u> 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>F.T. KASIK JR MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>2/11/67.</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | | 22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 24e. REC'D BY REGISTRAR <u>FEB 10 1967</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | DATE <u>FEB 10 1967</u> | |

DATE SIGNED

2/8/67

9005 Harford Rd. Balto Md

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|----------------------------------|---|--|--|--|--|---|--|
| 01819 | | | | | 01814 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Cockeysville</i> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Cockeysville</i> | | | d. STREET ADDRESS
<i>Boxer Hill Rd.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Boxer Hill Rd., Near Padonia Rd.</i> | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
<i>John MacCallum Gray</i> | | | First Middle Last | | 4. DATE OF DEATH
Month <i>February</i> Day <i>17</i> Year <i>1967</i> | | | | |
| 5. SEX
<i>Male</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>Sept. 2, 1896</i> | | 9. AGE (In years last birthday) Months Days
<i>70</i> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Electrical Engineer</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Consulting Engr.</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Scotland</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Robert Gray</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Mary Farmer</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>014-03-4608</i> | | 17. INFORMANT
<i>Family records</i> | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i>
<i>163X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>May 26, 1966</i> to <i>Feb 16, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb 14, 1967</i> , and that death occurred at <i>11</i> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>Thurman Kriger</i> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>Feb 17, 1967</i> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Cremation</i> | | | 23b. DATE THEREOF
<i>Feb. 20, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Greenmount Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Maryland</i> | | |
| 24. FUNERAL DIRECTOR
<i>John Burns' Sons, Towson, Maryland</i> | | | | | 25a. REC'D BY REGISTRAR
<i>FEB 23 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

01810

CERTIFICATE OF DEATH

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DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

| <div> <div> <div>2</div> <div>1</div> <div>M</div> </div> <div> <div>01820</div> <div>01815</div> </div> </div> <div> <div> <div>3</div> <div>4</div> </div> <div> <div>5</div> <div>6</div> </div> </div> | | | | | | | | | | | |
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et al., 1998).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01821 | | | | | | 01816 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY
<u>BALTIMORE</u> | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>RURAL BALTIMORE</u> | | | c. LENGTH OF STAY IN 1b
<u>20 YR</u> | | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1305 AINTREE RD.</u> | | |
| e. STATE
<u>MARYLAND</u> | | | f. COUNTY
<u>BALTIMORE</u> | | | g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>RURAL BALTIMORE</u> | | | h. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
<u>WILLIAM ELLSWORTH GROFF</u> | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>17</u> Year <u>1967</u> | | | 5. SEX
<u>M</u> | | | 6. COLOR OR RACE
<u>W</u> | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
<u>NOV. 17, 1913</u> | | | 9. AGE (in years last birthday)
<u>53</u> yrs. | | | 10. IF UNDER 1 YEAR
Months <u>13</u> Days <u>1</u> | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>EASTON PENNSYLVANIA USA</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>WILLIAM GROFF</u> | | | 14. MOTHER'S MAIDEN NAME
<u>HATTIE WURZBACHER</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u>087-09-9814</u> | | | 17. INFORMANT
<u>WIFE, NATALIE GROFF</u> | | | Address
<u>1305 AINTREE RD.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> | | | | | | | | | | | |
| 4201 DUE TO (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>20 YR</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>67</u> , to <u>FEB</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>FEB 11</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Samuel I. O'Mansky</u> | | | | | | 22b. DATE SIGNED
<u>FEB 18 1967</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>SAMUEL I. O'MANSKY</u> | | | | | | 22d. ADDRESS
<u>8523 LOCHRAVEN BLVD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF
<u>2-20-67</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>COCKEYSVILLE, MD.</u> | | | |
| 23d. LOCATION (City, town or county) (State) | | | | 24. FUNERAL DIRECTOR
<u>W.M. COCK-BROOKS, TOLSON, INC. TOLSON 4 MD</u> | | | | 25a. REC'D BY REGISTRAR
<u>FEB 20 1967</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01822

CERTIFICATE OF DEATH

01817

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN lb
1 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Joppa | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | d. STREET ADDRESS
414 Enfield Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Mary Kathleen HALES | | | | 4. DATE OF DEATH
Month Day Year
2 5 19 67 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-6-66 | |
| 9. AGE (In years last birthday) yrs.
9 | | 10. IF UNDER 1 YEAR
Months Days Min.
9 30 | | 11. IF UNDER 24 HRS.
Hours Min.
12 2 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Joseph Gratt Hales, Jr. | | | | 14. MOTHER'S MAIDEN NAME
Martha Eileen Buell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no -- | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspirational Pneumonia
DUE TO (b) Cerebral Atrophy
DUE TO (c) Hydrocephalus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 months
8 months
9 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12-30 , 19 66 , to 2-5 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-5 , 19 67 , and that death occurred 11:30 p.m. on Feb 6 1967 from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Richard A. Jones | | | | 22b. DATE SIGNED
6 Feb 67 | | 22c. PHYSICIAN'S NAME (Type)
Richard A. Jones | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rosewood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS
J. F. Eline & Sons Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 14 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Agitation (Fascism)
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Hydrocarbon

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Richard A. Jones
R. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01823

01818

| | | | | | |
|--|------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Balto. City
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2516 Anders Road | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Md.
b. COUNTY Baltimore Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Baltimore City
d. STREET ADDRESS
2516 Anders Road
a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
ARTHUR CHARLES HALLAM | | | 4. DATE OF DEATH
Month Feb. Day 14 Year 1967 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/20/1890 | | 9. AGE (In years last birthday)
76 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerical | | 10b. KIND OF BUSINESS OR INDUSTRY
Post office | | 11. BIRTHPLACE (County & State, or foreign country)
Chester, Pa. | |
| 13. FATHER'S NAME
Atlantis Hallam | | | 14. MOTHER'S MAIDEN NAME
Rachael Thompson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | | 16. SOCIAL SECURITY NO.
216 32 6272 | | |
| 17. INFORMANT
Mrs. A. C. Hallam | | | Address
2516 Anders Road | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 446X
DUE TO Kremia
(b) Nephrosclerosis
(c) Atherosclerotic Vascular Dis.
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1964 to Feb. 1967 that (I) (we) last saw the deceased alive on 2/13/67 and that death occurred at 1:21 M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
F.T. KASIK JR MD | | 22b. ADDRESS
9005 Harford Rd | | 22c. DATE SIGNED
2/14/67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | |
| 23d. LOCATION (City, town or county)
Baltimore, Md. | | 23e. (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
JOHN F. DENNY, INC. 715 Light St. | | 25a. REC'D BY REGISTRAR
FEB 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01823

Baltimore

Hotel - Balto. City

2515 Andara Road

ARTHUR

CHARLES

HALLAM

4/20/1960

Post Office

Clerical

Atlantic Hallam

Yes

Yes

216 38 8077 Mrs. A. C. Hallam 2515 Andara Road

Richard Thompson

Chester, Pa.

01818

Baltimore

Hotel - Baltimore City

2515 Andara Road

Feb. 14, 1961

57

Baltimore National

Baltimore, Md.

Feb 15 1961

John A. Henry, Inc. The Light Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

SHIPPED TO: V. Y. SCOTT FUNERAL HOME, BLACKSTONE, VA.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01824

CERTIFICATE OF DEATH

01819

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
40 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
1626 ASHBURTON STREET | |
| 3. NAME OF DECEASED (Type or print)
First EVERETT Middle HARDING Last | | 4. DATE OF DEATH
Month 2/13/67 Day 19 Year | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/24/05 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
JETERSVILLE, VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EVERETT HARDING | | 14. MOTHER'S MAIDEN NAME
MARIA WOODSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
719 18 07 79 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSP. FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5021 STATUS ASTHMATICUS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) PNEUMONIA, UNDETERMINED ORGANISM, BILATERAL
DUE TO
(c) CHRONIC OBSTRUCTIVE BRONCHITIS | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
ARTERIOSCLEROTIC HEART DISEASE, REMOTE MYOCARDIAL INFARCTION; GOUT; ADRENAL CORTICAL HYPOFUNCTION, SEC TO THERAPY | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/4/67 , 19__ to 2/13/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/13/67 , 19__, and that death occurred at 12:15A from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Neilon Neilson M.D. | | 22b. DATE SIGNED
2/15/67 | |
| 22c. PHYSICIAN'S NAME (Type)
NEILON NEILSON, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | 23b. DATE THEREOF
2-19-67 | 23c. NAME OF CEMETERY OR CREMATORY
Blackstone Crt | 23d. LOCATION (City or town) (County) (State)
Blackstone VA |
| 24. FUNERAL DIRECTOR
WILSON FUNERAL HOME | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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WASHINGTON

WASHINGTON

TO DIRECTOR

TO DIRECTOR

TO DIRECTOR

RE: [illegible]

RE: [illegible]

DATE

DATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

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2

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------|-------------------------|---|--|---|--|---|---|----------------------------|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 01825 | | | | | 01820 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY | | Baltimore | | | a. STATE | | Md. 21234 | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | b. COUNTY | | BALTIMORE | | | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | | | |
| 3042 California Ave. | | | | | 3042 California Ave. | | | | | | |
| e. IS RESIDENCE ON A FARM? | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED | | | | 4. DATE OF DEATH | | Month | | Day | | | |
| First Middle Last | | | | RUSSELL FRANKLIN HARE | | Feb. 22 | | 19 67 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | | | |
| male | | white | | NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9/1/1913 | | 53 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Shipping Md. Bolt & Nut Co. | | | | INDUSTRY | | Millers Station, Md | | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Clarence Hare | | | | | unknown | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | |
| | | | 184-12-5616 | | Virginia Minor Hare, wife, above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Rheumatic heart disease with</i> | | | | | | | | | | | |
| DUE TO (b) <i>mitral & aortic insufficiency</i> | | | | | | | | | years | | |
| DUE TO (c) <i>arthritis</i> | | | | | | | | | years | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| Hour a.m. p.m. 19 | | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1967, to Feb 22, 1967 that (I) (we) last saw the deceased alive on Feb 16, 1967, and that death occurred at 10:25 M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. | | |
| Dr. A. M. Bacon | | | | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | | 22b. DATE SIGNED | |
| Dr. A. M. Bacon | | | | | 2810 Taylor Ave. | | | | | 2/24/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 2/27/67 | | Moreland Mem. Park | | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. RECD BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | |
| Schimunek Funeral Home, Inc. | | | | | 3331 Brehms Lane | | FEB 28 1967 | | | J Charles Judge | |

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SECTION OF CIVIL

NO. 1134

8. 11. 1934

3043 California Ave. 3043 California Ave.

HUBBARD, LEO ALVA HANE

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Reg. Dist. No. 01821

01826

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Garrison | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Foxleigh Nursing Home | | | | d. STREET ADDRESS
21 W. Chatsworth | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Bessie Norris Harvey | | | | 4. DATE OF DEATH
Month Day Year
February 28, 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 28, 1880 | | 9. AGE (In years last birthday) yrs.
86 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. City | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Nicholas D. Norris | | | | 14. MOTHER'S MAIDEN NAME
Ida Stocksedale | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-30-7014 | | 17. INFORMANT
Address
Miss. Elizabeth N. Harvey Reisterstown, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
4201 DUE TO A.S.H.D. + high arterial sd
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO Pyelonephritis
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 hr.
20 yrs
45 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 49 to Feb 28, 1967 , that I last saw the deceased alive on Feb 26, 1967 , and that death occurred at 2 A. M. , from the causes and on the date stated above
ADDRESS (Street, city or town, state) DATE SIGNED
Palmer R. Williams M.D. Linson Rd. Bangs Mills, Md. 2/28/67
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) PALMER R. F. WILLIAMS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
3/2/67 | | 22c. NAME OF CEMETERY OR CREMATORY
Green Mount | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. F. Eline & Sons | | | | ADDRESS
Reisterstown, Md. | | 24a. REC'D BY REGISTRAR
DATE MAR 3 1967 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Charles Indel | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF BIRTH

| | | | | | | | | | |
|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF DEATH | | PLACE OF DEATH | |
| DATE OF BIRTH | | PLACE OF BIRTH | | CITY OF BIRTH | | STATE OF BIRTH | | COUNTRY OF BIRTH | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | RACE | |
| CAUSE OF DEATH | | MANNER OF DEATH | | PERIOD OF ILLNESS | | PREVIOUS ILLNESS | | PREVIOUS SURGERY | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESS | | SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF REGISTRAR | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |

MADE IN THE CITY OF NEW YORK
BY THE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
JANUARY 1900

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01827

CERTIFICATE OF DEATH

01822

| | | | | | | | | |
|--|----------------------------------|---|--|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Monkton</u> | | | c. LENGTH OF STAY in 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Monkton</u> | | | 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Carroll and Monkton Rds.</u> | | | | d. STREET ADDRESS
<u>Carroll and Monkton Rds.</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>LYDIA</u> Middle <u>PEARCE</u> Last <u>HARVEY</u> | | | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>28</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>August 6, 1886</u> | | 9. AGE (In years last birthday)
<u>80</u> yrs. | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Maiden lady</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>Henry Harvey</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Laura Pearce</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Family records</u> Address <u> </u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u>
<u>4221</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> , 19 <u>67</u> to <u>2/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>67</u> , and that death occurred at <u>2:28</u> P.M. from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
<u>A.M. France</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2/28/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>A.M. FRANCE</u> | | | | 22d. ADDRESS
<u>PARKTON, MD</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Mar. 2, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Monkton Methodist Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Monkton, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 6 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|----------------------------------|---|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01828 | | | | | 01823 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> 03-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1619 Greenspring Drive</u> | | | | | d. STREET ADDRESS
<u>1619 Greenspring Drive</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>C. LaRue</u> | | | First Middle Last | | 4. DATE OF DEATH
<u>February 15, 1967</u> | | Month Day Year | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Sept. 20, 1897</u> | | 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Welder-retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self employed</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>New York</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James Havens</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Helen Humphrey</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>187-14-3650</u> | | 17. INFORMANT
<u>Family records</u> | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ART. SCLEROTIC C.V. DISEASE</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>17 YR.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>18 JAN 1967</u> to <u>2-15-67</u> , that (II) we last saw the deceased alive on <u>2-15-1967</u> , and that death occurred on <u>2-15-67</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Donald O Wood M.D.</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
<u>2/17/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>Feb. 18, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Grace-Falls Road Methodist</u> | | 23d. LOCATION (City, town or county) (State)
<u>Cockeysville, Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR
<u>DATE FEB 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

01824

01824

CERTIFICATE OF DEATH

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Witness" are faintly visible.]



VR A15 (4)
20M 1/65

01829

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| | | | | | |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>ELICOTT CITY</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Shady Rock Nursing Home</u> | | d. STREET ADDRESS
<u>382 CHAPEL VIEW RD</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>FRANCES</u> Middle <u>C</u> Last <u>HAYS</u> | | 4. DATE OF DEATH
Month <u>FEB</u> Day <u>14</u> Year <u>1967</u> | | | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov 12 - 1888</u> | 9. AGE (In years last birthday)
<u>84</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>SCHOOL TEACHER</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>PENNA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME
<u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>266-76-3862</u> | | 17. INFORMANT
<u>Francis Hoskin</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
<u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>CARCINOMATOSIS</u>
(c) <u>CARCINOMA - BREAST</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 YR</u>
<u>5 YR</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | | 20h. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> , 19 <u>66</u> to <u>2-14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-13</u> 19 <u>67</u> , and that death occurred at <u>1205</u> A.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>John V. Throckmorton</u> | | 22b. DATE SIGNED
<u>2-16-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>2-18-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GREEN HILL CEM</u> | |
| 23d. LOCATION (City, town or county) (State)
<u>Johnstown, Ohio</u> | | 23e. LOCATION (City, town or county) (State)
<u>Johnstown, Ohio</u> | | 23f. LOCATION (City, town or county) (State)
<u>Johnstown, Ohio</u> | |
| 24. FUNERAL DIRECTOR
<u>John V. Throckmorton</u> | | 24a. ADDRESS
<u>Ellicott City, Md</u> | | 24b. REC'D BY REGISTRAR
<u>Charles J. Jones</u> | |
| 24c. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | 24d. DATE
<u>FEB 17 1967</u> | | 24e. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | |

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1 Y. 1
2 Y. 2

TESSON INCORPORATED
ELECTROCHEMICALS
CORPORATION - BOSTON

10-1-5

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01830

CERTIFICATE OF DEATH

01825

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN 1b
10 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | d. STREET ADDRESS
7004 Boxwood Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Israel Middle Jacob Last HERTZBERG | | 4. DATE OF DEATH
Month 2 Day 6 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-27-55 |
| 9. AGE (In years last birthday)
11 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Irving Hertzberg | | 14. MOTHER'S MAIDEN NAME
Esther Tenenbaum | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no -- | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shigellosis
045.0 DUE TO Shigella flexneri Group B
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Profound Mental Retardation
DUE TO (c) Mongolism | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
? Progeria ? | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (if) (this hospital) attended the deceased from 3-24 , 19 66 , to 2-6 , 19 67 , that (if) (we) last saw the deceased alive on 2-6 19 67 , and that death occurred at 8:54 Matron causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. Crosby Greene M.D. | | 22b. DATE SIGNED
2-6-67 | |
| 22c. PHYSICIAN'S NAME (Type)
D. Crosby Greene, M.D. | | 22d. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/7/67 | 23c. NAME OF CEMETERY OR CREMATORY
Rosedale | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md |
| 24. FUNERAL DIRECTOR
Sylvan S. Lewis & Son Inc. Garrison, Md | | 25a. REC'D BY REGISTRAR
DATE FEB 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01831

CERTIFICATE OF DEATH

01826

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>
c. LENGTH OF STAY IN 1b <u>2 YEARS</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenarm Road</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>
d. STREET ADDRESS <u>Glenarm Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Sister Mary Eustelle Hess</u>
First Middle Last
4. DATE OF DEATH <u>February 17 1967</u>
Month Day Year | | 5. SEX <u>Female</u>
6. COLOR OR RACE <u>W</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 12, 1885</u>
9. AGE (In years lost birthday) <u>82 1/2</u> yrs.
IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teacher</u>
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>John Hess</u>
14. MOTHER'S MAIDEN NAME <u>Mary Ann Fisher</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>
16. SOCIAL SECURITY NO. <u>217-54-9784</u>
17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma, left breast</u>
<u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Infiltration axillary vein</u>
<u>Pulmonary & General bone metastasis</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 year</u>
<u>1 year</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u>
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1966</u> , to <u>Feb 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 5, 1966</u> , and that death occurred at <u>6:50 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>S. G. Sullivan</u>
22c. PHYSICIAN'S NAME (Type) <u>S. G. Sullivan</u> | | 22b. DATE SIGNED <u>2-22-67</u>
22d. ADDRESS <u>1129 St Paul St Baltimore 2 Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>
23b. DATE THEREOF <u>2-20-1967</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Sister s Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Glen Arm, Maryland</u> | | 24. FUNERAL DIRECTOR <u>Raymond J. Curran</u> ADDRESS <u>817 Scarlett Dr. Towson, Maryland</u>
25a. REC'D BY REGISTRAR <u>FEB 28 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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GRANDCHILD OF DEATH

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1921 DEC 22

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01832

01827

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK</u> <u>03-1</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>7446 MANCHESTER RD</u> | | | | d. STREET ADDRESS
<u>7446 MANCHESTER RD</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>HENRY W. HICKMAN</u> | | | | 4. DATE OF DEATH
Month <u>FEB</u> Day <u>10</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>SEPT. 5, 1906</u> | | 9. AGE (In years last birthday)
<u>60</u> yrs. | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>CHARLES HICKMAN</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARTHA AMOS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>UNK</u> | | 16. SOCIAL SECURITY NO.
<u>218-05-3755</u> | | 17. INFORMANT
<u>EMMA HICKMAN</u> | | Address
<u>ABOVE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4221 A-S-C-V- DISEASE</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u>
DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>NR</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>M.B. Davis</u> | | EXAMINER'S NAME (Type)
<u>M.B. Davis MD-6800 MURNING</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
<u>2/13/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>FEB. 13, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>SACRED HEART</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO. MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>J.G. CONNELLY SONS</u> | | ADDRESS
<u>300 MACE</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01833

CERTIFICATE OF DEATH

01828

| | | | | | | | |
|---|-----------------------------|--|-----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>21204</u> ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| c. LENGTH OF STAY IN 1b <u>18 days</u> | | | | d. STREET ADDRESS <u>4308 Forestview Ave</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med-Center</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Frederick Arnold Hightman</u> | | | | 4. DATE OF DEATH <u>2 11 1967</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-10-1976</u> | | 9. AGE (In years last birthday) <u>91</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lutheran Minister</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Burkittsville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Martin Luther</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN Loretta Arnold</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>213-36-8407A</u> | | | |
| 17. INFORMANT <u>Rev. Schylze - Pope & Marluth Ave</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u>
5272 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration pneumonia of infarction</u>
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>67</u> , to <u>Feb 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Mario B. Ines M.D.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u>2-11-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>MARIO B. INES M.D.</u> | | | | 22d. ADDRESS <u>GBMC</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2-15-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Co. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u> ADDRESS <u>34 2401 Belair Road</u> | | | | 25a. REC'D BY REGISTRAR <u>FEB 17 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01888

01888

Cooperative Insurance of California
Central Insurance Company

MADE IN U.S.A.
MADE IN U.S.A.

2-11-67
Feb 11 67
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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01834

Reg. Dist. No. 01829

| | | | | | | | |
|--|---------------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Baltimore</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Baltimore</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>SPARROWS POINT</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>SPARROWS POINT 19, 13-1</u> | | TOWN | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>807 J Street</u> | | | | STREET ADDRESS (If rural give location)
<u>807 J Street</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>Benjamin</u> (First) <u>Hill</u> (Middle) <u>Hill</u> (Last) | | | | 4. DATE OF DEATH
(Month) (Day) (Year)
<u>February 24</u> <u>1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>Col</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
<u>MARRIED</u> | 8. DATE OF BIRTH
<u>November 14, 1897</u> | | 9. AGE last birthday
<u>74</u> yrs. | | IF UNDER 1 YEAR
Months <u>3</u> Days <u>8</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>STEEL WORKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>STEEL PLANT</u> | | 11. BIRTHPLACE (State or foreign country)
<u>NORTH CAROLINA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Joe Hill</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Annie Hill</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>213-07-6541</u> | | 17. INFORMANT & ADDRESS
<u>Annie Hill 807 J. Street</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 163X IMMEDIATE CAUSE (A) <u>Pneumonia</u> | | | | | | <u>1 day</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Failure</u> | | | | | | <u>3 days</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Carcinoma Lung</u> | | | | | | <u>1 yr.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>December 14, 1965</u>, to <u>February 24, 1967</u>, that I last saw the deceased alive on <u>February 14, 1967</u>, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>William C. Stade</u> | | M.D.
<u>140 Oak Ave. Dundalk, Md.</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED
<u>2/24/67</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>Burial</u> | | DATE THEREOF
<u>2-28-67</u> | | NAME OF CEMETERY OR CREMATORY
<u>Arbutus Mem. Park</u> | | LOCATION (City, town, or county)
<u>Arbutus</u> | |
| 24. REC'D BY REGISTRAR
<u>FEB 28 1967</u> | | REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>Morton E. Dyck F.H.</u> | | ADDRESS
<u>1701 Laurens</u> | |

CERTIFICATE OF DEATH

01834

01834

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. DISEASE OR INJURY

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF SHERIFF'S DEPUTY

19. SIGNATURE OF SHERIFF'S CLERK

19. SIGNATURE OF SHERIFF'S CLERK

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42. SIGNATURE OF SHERIFF'S CLERK

42. SIGNATURE OF SHERIFF'S CLERK

43. SIGNATURE OF SHERIFF'S CLERK

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01835

CERTIFICATE OF DEATH

Reg. Dist. No. 01830

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural - Randallstown</u> | | c. LENGTH OF STAY IN 1b
<u>Life</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural - Randallstown</u> | | d. STREET ADDRESS
<u>Holbrook Road</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Holbrook Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Bettie</u> Middle <u>S.</u> Last <u>Holbrook</u> | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>11</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 17, 1881</u> |
| 9. AGE (In years last birthday)
<u>85</u> yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>House work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Ezra Holbrook</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Smith</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-38-9849</u> | |
| 17. INFORMANT
<u>Mr. Herbert Holbrook - Randallstown, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
<u>331X</u> DUE TO <u>Arterial hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2/10/67</u> , to <u>2/11/67</u> , that I last saw the deceased alive on <u>2/10/67</u> , and that death occurred at <u>4:02</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Wm. E. Martin</u> | | ADDRESS (Street, city or town, state)
<u>Randallstown</u> | |
| PHYSICIAN'S NAME (Type)
<u>Wm. E. Martin</u> | | DATE SIGNED
<u>2/21/67</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>2-13-67</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Wards Chapel Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Sykesville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Harry W. Naight</u> | | ADDRESS
<u>Sykesville, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE
<u>FEB 16 1967</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 (M)

01836

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01831

| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore Maryland</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>1813 Aberdeen Road</u> | | |
| c. LENGTH OF STAY IN 1b
<u>3 days</u> | | | d. STREET ADDRESS
<u>1813 Aberdeen Road</u> | | |
| 4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Medical Center</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Ethel</u> First <u>M</u> Middle <u>Holokai</u> Last | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>13</u> Year <u>1967</u> | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>CAU</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<u>08-20-24</u> | | 9. AGE (In years last birthday)
<u>42</u> yrs. | | 10. IF UNDER 13 MONTHS Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SECRETARY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>URBAN RENOVATION</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>HARLAN Co. Ky</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>Robert Lee White</u> | | 14. MOTHER'S MAIDEN NAME
<u>GARLAND</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Patient's Chart</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL SUBARACHNOID HEMORRHAGE</u>
330X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RUPTURED BERRY ANEURYSM OF</u>
DUE TO <u>CIRCLE OF WILLIS</u> (c)
INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 1967, to <u>2-13</u> , 1967, that (I) (we) last saw the deceased alive on <u>2-13</u> , 1967, and that death occurred at <u>2:30 P.</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Henri T. Voorstad</u> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-13-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>HENRI T. VOORSTAD</u> | | 22d. ADDRESS
<u>G.B.M.C.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>2/17/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Balto. Natl Cemetery</u> | |
| 23d. LOCATION (City or Town)
<u>Baltimore</u> | | (County) | | (State)
<u>md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Carley Caranough</u> | | ADDRESS
<u>6601 Frederick Ave</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 16 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | | | |

01881

01881

CERTIFICATE OF DEATH

Whereas the undersigned is a duly qualified and licensed
Physician, I hereby certify that the person named below
has died of the disease or injury specified, and that the
cause of death is as stated, and that the death occurred
on the day and at the place specified.

Given under my hand and the seal of my office
this 1st day of January, 1901.

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01837

CERTIFICATE OF DEATH

01832

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cockeysville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frostburg</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bonnie Blink Masonic Home</u> | | d. STREET ADDRESS
<u>78 Mechanic Street.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Janet</u> Middle <u>A.</u> Last <u>Hotchkiss</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>3</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 23, 1886</u> |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u> </u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Longacoring, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Peter McFarland</u> | | 14. MOTHER'S MAIDEN NAME
<u>Janet Muir</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-14-7972</u> | |
| 17. INFORMANT
<u>Records of Md. Masonic Home, Cockeysville</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u>
DUE TO (c) <u>Skin abscess secondary to Burn</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> o.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | 20f. (City or town) (County) (State)
<u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1965</u> , 19 <u>65</u> to <u>Feb 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb 3</u> , 19 <u>67</u> , and that death occurred at <u>4:45</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>JAMSHID HAMED.</u> | | 22b. DATE SIGNED
<u>FEB 3, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMSHID HAMED.</u> | | 22d. ADDRESS
<u>MASONIC HOME</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2-6-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Alleghany Cemetery-Frostburg, Maryland</u> | 23d. LOCATION (City or Town) (County) (State)
<u> </u> |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u> | | 25a. REC'D BY REGISTRAR
<u> </u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE <u>FEB 6 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---------------------------------------|---|--|--|--|--|--|---|
| 01838 | | | | | 01833 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>
c. LENGTH OF STAY IN 1b <u>6 yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St Joseph Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>BALTO</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>
d. STREET ADDRESS <u>2703 FIFTH AVE</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>MARTIN</u> Middle <u>J</u> Last <u>HRADSKY</u> | | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>21</u> Year <u>1967</u> | | 5. SEX <u>M</u> | | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan 5 1911</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR
Months <u>56</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Traf. Rate Clerk</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Crown C & S</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Frank Hradsky</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Troch</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>***** 213-01-0329</u> | | 17. INFORMANT <u>Family records</u> Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>
DUE TO (b) <u>Acute bacterial myocardial infarction</u>
DUE TO (c) <u>4201</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u> | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> , to <u>June</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>67</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>E. P. Coffey Jr.</u> | | | | | 22b. DATE, SIGNED <u>2/21/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>E. P. COFFEY JR.</u> | | |
| 22d. ADDRESS <u>3100 ST PAUL ST</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>2/25/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u> | | 23d. LOCATION (City, town or county) (State) <u>Balto Md</u> | | |
| 24. FUNERAL DIRECTOR <u>CHAS. F. EVANS JR</u> | | | ADDRESS <u>8802 Harford Rd</u> | | 25a. REC'D BY REGISTRAR <u>PL</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01834

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>619 Horncrest Rd</u> | | d. STREET ADDRESS
<u>619 Horncrest Rd</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>E. Milton Hueter Sr</u> | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>5</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2-25-91</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Soleman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Real Estate</u> | 9. AGE (In years last birthday) <u>75</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Charles E Hueter</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Deichmann</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-01-2263</u> | |
| 17. INFORMANT
<u>Lillian B Hueter</u> | | Address
<u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardio-Vascular Disease</u>
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> , 19 <u>67</u> , to <u>Feb</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>Feb 5</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William G Helfrich</u> | | 22b. DATE SIGNED
<u>2-6-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William G Helfrich</u> | | 22d. ADDRESS
<u>3006 Roland Ave, Balto, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>2-9-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley</u> | 23d. LOCATION (City, town or county) (State)
<u>BALTO MD</u> |
| 24. FUNERAL DIRECTOR
<u>Mrs. F. Evans & Son</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>8802 Hanford Rd</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE
<u>FEB 14 1967</u> | | | |

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[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---------------------------|---|--|--|---|---|-------------------------------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 01840 | | | | | 01835 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
8431 Greenway Road | | | | | d. STREET ADDRESS
8431 Greenway Rd. | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
PAUL H. HUTCHINS, Sr. | | | 4. DATE OF DEATH
Month Day Year
February 7, 1967 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5/19/1901 | | 9. AGE (In years last birthday) 65 | | |
| 1da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk, Alcoa Steamship Co. | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 13. FATHER'S NAME
Charles Lee Hutchins | | | | | 14. MOTHER'S MAIDEN NAME
Johanna Conroy | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | 16. SOCIAL SECURITY NO.
215-18-3830 | | 17. INFORMANT
Mrs. B. Martha Hutchins | | | Address
8431 Greenway Road | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>coronary occlusion</i>
4201 DUE TO (b) <i>arteriosclerotic heart disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 2da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan., 1959, to Dec., 1966, that (I) (we) last saw the deceased alive on 12-22-1966, and that death occurred at M, from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
Dr. Eugene Schnitzer | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. ADDRESS
3904 Hanover St., Baltimore 25, Md. | | 22b. DATE SIGNED
Feb. 8, 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
2/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial | | 23d. LOCATION (City, town or county) (State)
Balto., County, Md. | | | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | | | | ADDRESS
6500 York Rd. | | 25a. REC'D BY REGISTRAR
DATE FEB 14 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01841

CERTIFICATE OF DEATH

01836

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville 28 | | c. LENGTH OF STAY IN 1b
1 month | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
House in the Pines Nursing Home | | d. STREET ADDRESS
2830 Rona Road | |
| 3. NAME OF DECEASED (Type or print)
Amy Alma Ireland | | 4. DATE OF DEATH
Feb. 28 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-16-1883 |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Saleswoman | | 10b. KIND OF BUSINESS OR INDUSTRY
Saleswoman | |
| 11. BIRTHPLACE (County & State, or foreign country)
Calvert Co. Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Cornelius O. Robinson | | 14. MOTHER'S MAIDEN NAME
Ellen - | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
214-14-7499 | |
| 17. INFORMANT
Alma Dorsey-702 E. Maple Rd. Maryland | | Address Linthicum Hgts | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mitralatic Ca of Lung
1539 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of Intestines DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH
6-7 mo.
230 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-25 , 1967, to 2-28 , 1967, that (I) (we) last saw the deceased alive on 2-27 1967, and that death occurred at 8:30 M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Wilmer K. Gallagher | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher | | 22d. ADDRESS
6209 Frederick St. - Balt 21228 Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
3-3-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Ellsworth Armace | | 25a. REC'D BY REGISTRAR
MAR 2 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

01301

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11-13-2010 BY 60322
EX-100

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01842

CERTIFICATE OF DEATH

01837

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
<div style="text-align: right;">MARYLAND</div> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN 1b
21 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Deposit RURAL | |
| 3. NAME OF DECEASED (Type or print)
First Barbara Middle Lee Last JACKSON | | 4. DATE OF DEATH
Month 2 Day 27 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-26-41 |
| 9. AGE (In years last birthday)
26 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | |
| 11. BIRTHPLACE (County & State, or foreign country)
Rising Sun, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Howard Dennison Jackson, Jr. | | 14. MOTHER'S MAIDEN NAME
Mary Alice Yocum | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Rosewood Records, Owings Mills, Maryland | | Address | |

| | | |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Necrotizing bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Aspiration
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
10 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | |
| 21. I certify that (X) (this hospital) attended the deceased from 8-15 , 19 45 , to 2-27 , 19 67 , that (X) (we) last saw the deceased alive on 2-27 , 19 67 , and that death occurred at 10:00 a.m. from causes and on the date stated above. | | |
| 22a. SIGNATURE
Richard A. Jones | | 22b. DATE SIGNED
27 Feb 67 |
| 22c. PHYSICIAN'S NAME (Type)
Richard A. Jones | | 22d. ADDRESS
Rosewood state Hosp |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
3-1-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Ebenzer Cem |
| 23d. LOCATION (City or Town) (County) (State)
Rising Sun Cecil Md. | | |
| 24. FUNERAL DIRECTOR
Richard L. Goodie | | 25a. REC'D BY REGISTRAR
Charles Judge |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
MAR 1 1967 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01810

STATEMENT OF WORK

01810

| Item | Description | Quantity | Unit Price | Total Price |
|------|-------------|----------|------------|-------------|
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STATEMENT OF WORK
01810

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01843

CERTIFICATE OF DEATH

01838

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b
Baltimore 21212 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
5801 Chinquapin Parkway | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Mayme Virginia JAEGER | | | | 4. DATE OF DEATH
Month Day Year
February 20, 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 23, 1885 | | 9. AGE (In years last birthday)
82 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William H. Stauffer | | | | 14. MOTHER'S MAIDEN NAME
Emma S. Ziegler | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
219-42-0483 | | 17. INFORMANT
Address
James C. Burch, 15 W. Mulberry St. Balto. Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary embolism
1530 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the cecum.
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 11 (this hospital) attended the deceased from 2/9/ , 19 67 , to 2/20/ , 19 67 , that 11 (we) last saw the deceased alive on 2/20/ , 19 67 , and that death occurred at 12:15M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Lawrence F. Misanik</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
February 20, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/22/67. | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR
DATE FEB 21 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. ...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01838

SECTION OF DEATH

01844

| | | | |
|-----------------------------|--|---------------|--|
| Name of Deceased | | Date of Death | |
| John Doe | | 1912 | |
| Age | | 35 | |
| Sex | | Male | |
| Marital Status | | Single | |
| Occupation | | Teacher | |
| Cause of Death | | Disease | |
| Place of Death | | Home | |
| Time of Death | | 10:00 AM | |
| Signature of Doctor | | [Signature] | |
| Signature of Witness | | [Signature] | |
| Signature of Coroner | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Signature of Burial Officer | | [Signature] | |
| Signature of Undertaker | | [Signature] | |
| Signature of Minister | | [Signature] | |
| Signature of Priest | | [Signature] | |
| Signature of Rabbi | | [Signature] | |
| Signature of Imam | | [Signature] | |
| Signature of Other | | [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01844

CERTIFICATE OF DEATH

01839

| | | | | | | | |
|---|--|--|---|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY in 1b
16 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore - 21218 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
2007 E. 32nd Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Frieda M. Johanns | | | | 4. DATE OF DEATH
Month Day Year
Feb. 20, 1967 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-21-91 | |
| 9. AGE (In years lost birthday) yrs.
75 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Germany | |
| 13. FATHER'S NAME
Geschwendt | | | | 14. MOTHER'S MAIDEN NAME
Margaret Otten | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
213-32-2858B | | 17. INFORMANT Address
Mr. Karl F. Johanns, Same as # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 4 , 1967, to Feb. 20 , 1967, that (I) (we) last saw the deceased alive on Feb. 20 , 1967, and that death occurred at 11:15 from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
Feb. 20 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Ramon P. Lopez M.D. | | | | 22d. ADDRESS
7620 York Road-Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
FEB. 24, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co., Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR
FEB 23 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles J... | |

11813

012310

EXTRACT OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|-----------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 2/10/67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shangri-La Nursing Center | | 2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4101 Glen Hunt Road
d. STREET ADDRESS Baltimore, Maryland
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lillian T. Jones
First Middle Last | | 4. DATE OF DEATH Feb 18 1967
Month Day Year | |
| 5. SEX Fem. | 6. COLOR OR RACE Wh. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/12/1897
9. AGE (In years last birthday) 69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothes Fitter (Ret.) | | 10b. KIND OF BUSINESS OR INDUSTRY Hutzler Bros. | |
| 11. BIRTHPLACE (County & State, or foreign country) Pulaski, Va. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James Rayburn Taylor | | 14. MOTHER'S MAIDEN NAME Margaret Ritter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) . | | 16. SOCIAL SECURITY NO. 230-10-5606 | |
| 17. INFORMANT Samuel P. Jones | | Address 8319 Wyton Road 4 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration + Malnutrition
DUE TO 157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laundering + Chronic diarrhea
DUE TO (c) Carcinoma of Pancrease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June, 1966 , to Feb., 1967 , that (I) (we) last saw the deceased alive on Feb. 25 1967 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE William J Bryson | | 22b. DATE SIGNED 26 Feb-67 | |
| 22c. PHYSICIAN'S NAME (Type) William J Bryson | | 22d. ADDRESS 4605 Edmondson Ave Balto 29 Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3-1-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cem. | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Witzke F.D.-4101 Edmondson Ave. | | 25a. REC'D BY REGISTRAR FEB 28 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

11810

23810

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01846

CERTIFICATE OF DEATH

01842

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosehill Station</u> | | c. LENGTH OF STAY IN 1b <u>Two Weeks</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u> | | d. STREET ADDRESS <u>5909 Edmondson Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Gilbert</u> First <u>Jordan</u> Middle <u>Jordan</u> Last | | 4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> Year <u>1967</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-13-87</u> |
| 9. AGE (In years lost birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>03</u> - Days <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - Meat Buyer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Celix</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>87-07-1779</u> | |
| 17. INFORMANT <u>PEARL JORDAN - SAME</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
578X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Massive Pulmonary Congestion</u>
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post operative (1-30-67) Intestinal Resection of gangrenous 2 feet of ileum</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>67</u> , to <u>2-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Albert S. Barretto</u> | | 22b. DATE SIGNED <u>2-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALBERTO S. BARRETTO</u> | | 22d. ADDRESS <u>Balto. Cty. Gen. Hosp., old Ct. Rd., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>2-15-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Somerton, Pennsylvania</u> |
| 24. FUNERAL DIRECTOR <u>Ellsworth Chinos</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 4600 Liberty Hghts. Avenue | | DATE <u>FEB 14 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25810

22810

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01847

CERTIFICATE OF DEATH

01843

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
2 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
13 E. Overlea Avenue | |
| 3. NAME OF DECEASED
(Type or print)
First Anna Middle M. Last Kaltenbach | | 4. DATE OF DEATH
Month Feb. Day 20 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-20-93 |
| 9. AGE (In years last birthday)
73 yrs. | | 10. IF UNDER 1 YEAR
Months 23 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Christian Richter | | 14. MOTHER'S MAIDEN NAME
? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
220-09-3246d | |
| 17. INFORMANT
Christian Richter | | Address
17 E Overlea Ave 21206 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction, left ventricle.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis right coronary artery.
DUE TO
(c) Arteriosclerosis generalized severe. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Multiple pulmonary infarctions, right lung. | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 18 , 19 67 , to Feb. 20 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 20 , 1967, and that death occurred at 4:50 p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>M.S. Cockburn M.D.</i> | | 22b. DATE SIGNED
February 21, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/23/67 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | 25a. REC'D BY REGISTRAR
MAR 1 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. REGISTRAR'S NAME
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CRIMINAL RECORD

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01848

01844

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN lb
Arbutus | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Paradise Nursing Home | | e. STREET ADDRESS
5009 Leeds Avenue | |
| 3. NAME OF DECEASED (Type or print)
MARY A. KASINSKAS | | 4. DATE OF DEATH
Month February , Day 7 , Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-24-1884 |
| 9. AGE (In years lost birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months 03 Days 1 Hours 0 Min. 0 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY
Lithuaina | |
| 12. BIRTHPLACE (County & State, or foreign country)
Lithuaina | | 13. CITIZEN OF WHAT COUNTRY?
Lithuaina | |
| 14. FATHER'S NAME
Joseph Saukatis | | 15. MOTHER'S MAIDEN NAME
Catherine Motckevic | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 17. SOCIAL SECURITY NO.
Mr. William L. Kasinskas, 5009 Leeds Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia extreme
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive G.S.C.O.D.
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 19 67 , to 19 66 , that (I) (we) last saw the deceased alive on Feb. 7 1967 , and that death occurred at 12:32 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stanley Ankudas | | 22b. DATE SIGNED
2.8.67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Stanley Ankudas | | 22d. ADDRESS
1101 Maiden Choice Lane | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2-10-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR
DATE FEB 10 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 01849 | | | | | 01845 | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) | | | | | |
| a. COUNTY | | BALTIMORE | | | a. STATE | | maryland | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Baltimore 12 | | | b. COUNTY | | City of Balto. | | | |
| c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | City of Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? | | | |
| Armocost Nursing Home - Regester Av. | | | | | 3802 Fenchurch Road | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | Month Day Year | | | |
| MADELON BLATCHFORD KAYSER | | | | | Feb. 26, 1967 | | 19 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | |
| Female | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Feb. 7, 1901 | | 66 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| NONE | | | | | NONE | | Bedford Co., Pa. | | USA | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| John K. Blatchford | | | | | Anna Jenkins | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| NO | | NONE | | husband | | Balto., 21218 | | | | |
| | | | | Dr. Fayne A. Kayser | | 3802 Fenchurch Rd., | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>
4201 DUE TO
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-Sclerosis</i>
DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<i>Cirrhosis of Liver</i> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 14, 1967</i> to <i>Feb. 26, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb. 14, 1967</i> , and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
<i>Madelon Blatchford</i> | | | | | | 22b. DATE SIGNED
<i>2/28/67</i> | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | |
| | | | | | | <i>Med-City Bldg. Dattin Dr.</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | | |
| BURIAL | | 3/1/1967 | | Druid Ridge | | Pikesville, Balto. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Stewart & Mowen Co. 108 W. North Av., Balto. | | | | 21201 | | DATE MAR 1 1967 | | <i>Charles Judge</i> | | |

01819

01819

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

Blank form with horizontal lines for text entry.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01850

CERTIFICATE OF DEATH

01846

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|--|----------------------------------|---|--|---|---|---|-------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN lb
1 DAY | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RIVERA BEACH | | | <i>02-2</i> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
233 MEADOW ROAD | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
JAMES FRANCIS KEARNEY | | First Middle Last | | 4. DATE OF DEATH
FEBRUARY 27 19 67 | | Month Day Year | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCTOBER 3, 1895 | | 9. AGE (In years last birthday) yrs.
71 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CRANE OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY
STEEL | | 11. BIRTHPLACE (County & State, or foreign country)
IRELAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
THOMAS KEARNEY | | | | 14. MOTHER'S MAIDEN NAME
MARY FLYNN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
207 05 30 49 | | 17. INFORMANT
VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
491X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
CARCINOMA OF PROSTATE | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB. 26 , 19 67 , to FEB 27 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB. 27 , 19 67 , and that death occurred at 930P M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Howard C. Kramer</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2/28/67 | |
| 22c. PHYSICIAN'S NAME (Type)
HOWARD C. KRAMER, M.D. | | | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar. 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
George J. Gonce
Gonce Funeral Home | | | | ADDRESS 4001 Gov Ritchie Hwy
Balto, Md. | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01851

CERTIFICATE OF DEATH

01847

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|--|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
1 DAY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
3210 WEST BALTIMORE STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle EIMHORST Last KELLEY | | | | 4. DATE OF DEATH
Month FEBRUARY Day 13 Year 19 67 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 31, 1918 | | |
| 9. AGE (In years last birthday)
48 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> | | IF UNDER 24 HRS.
Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
EDWARD J. KELLEY | | | | 14. MOTHER'S MAIDEN NAME
ROSALEE EIMHORST | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | | 16. SOCIAL SECURITY NO.
216 01 62 71 | | 17. INFORMANT
VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION OF RIGHT LUNG
DUE TO 454X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
THROMBOSIS OF ABDOMINAL AORTA WITH OCCLUSION OF COMMON ILIAC ARTERIES | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB. 12 , 19 67 , to FEB. 13 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB. 13 , 19 67 , and that death occurred at 1245A , from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
<i>Sheldon E. Kalmutz</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2/13/67 | | |
| 22c. PHYSICIAN'S NAME (Type)
SHELDON E. KALMUTZ, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-15-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
WITZKE FUNERAL HOME
4101 EDMONDSON AVE. BALTIMORE, MD. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 15 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01852

CERTIFICATE OF DEATH

01848

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Owings Mills</u> | | | c. LENGTH OF STAY IN 1b
<u>App. 7 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Rosewood State Hospital</u> | | | | d. STREET ADDRESS
<u>1500 Lakeside Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Jerome</u> Middle <u>G.</u> Last <u>Kelly Jr.</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-29-65</u> | | 9. AGE (In years last birthday)
<u>1</u> yrs. | IF UNDER 1 YEAR
Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>--</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>--</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Mr. Jerome G. Kelly</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Mauldin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>--</u> | | 16. SOCIAL SECURITY NO.
<u>--</u> | | 17. INFORMANT
<u>Rosewood State Hospital Medical Records</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Infection - site undetermined</u>
<u>7531</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>--</u>
DUE TO
(c) <u>--</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Microcephaly; severe mental retardation</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>--</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u>
p.m. <u>--</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>--</u> | | 20f. (City or town) (County) (State)
<u>--</u> | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>2-12-67</u> , 19 <u>67</u> , to <u>2-28-67</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>2-28-67</u> , 19 <u>67</u> , and that death occurred on <u>2-28-67</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Dr. Zieve</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Zieve</u> | | | | 22d. ADDRESS
<u>ROSEWOOD STATE HOSPITAL</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3-3-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co. 4905 York Rd., Baltimore</u> | | | | 25a. REC'D BY REGISTRAR
<u>2</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01882

CERTIFICATE OF DEATH

01882

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|------------------|--|-----|--|-----|--|---------------|--|----------------|--|-----------------|--|----------------|--|---------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G386 3/6/67 mh

01853

CERTIFICATE OF DEATH

01849

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|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Idlewild
c. LENGTH OF STAY IN b
ARMACOST NURSING HOME | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY 30.4
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
/812/ Regester St./ Baltimore
d. STREET ADDRESS
2516 E. Madison St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First MARY Middle KLECKA Last
4. DATE OF DEATH
Month February Day 18 Year 19 67 | | 5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/5/77 9. AGE (In years last birthday) 89
IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Slechta | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
215-22-4782 | | 16. SOCIAL SECURITY NO.
215-22-4782 | |
| 17. INFORMANT
Mildred Pretl, neice, 2109 Woodburn Ave | | Address 21214 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1443X
DUE TO 1. occlusive arterial disease both lower
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2. Thrombosis due to arteriosclerosis and gangrene
DUE TO 3. Arteriosclerotic heart disease
4. Hypertensive cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
gen'l arteriosclerosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1962 to Feb 18, 1967 , that (I) (we) last saw the deceased alive on Feb 17, 1967 , and that death occurred at 7:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Donald W. Mintzer | | 22b. DATE SIGNED
Feb 20 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Donald Mintzer | | 22d. ADDRESS
3009 Evergreen Ave. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/21/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Bohemian National Cem | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
2601 E. Madison St. | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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| | | | | | | | |
|---|------------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Baltimore County General Hospital | | | | d. STREET ADDRESS
7017 Queen Anne's Road | | | |
| 3. NAME OF DECEASED (Type or print)
First BARRY Middle L. KLINE Last KRISTEN | | | | 4. DATE OF DEATH
Month 2 Day 28 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/26/1949 | 9. AGE (In years lost birthday) yrs.
18 | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Rev. Theodore Kline | | | | 14. MOTHER'S MAIDEN NAME
Beulah Deal | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Rev. Theodore Kline-7017 Queen Anne Rd. 21207 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Idiopathic cardiomyopathy
4344 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Russell S. Fisher | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county)
700 Fleet St. Baltimore, Md. 21202 | | | | 22. DATE SIGNED
3-1-67 | |
| EXAMINER'S NAME (Type)
RUSSELL S. FISHER, M.D. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/3/67 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Taylor Ave. Balt. Md. | | | |
| 24. FUNERAL DIRECTOR
Loring Byers-3728 Liberty Rd. Randallstown, Md. | | | | 25a. REC'D BY REGISTRAR
MAR 6 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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Rev. Jacobus A. de Vries, D.D.,

and

of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|-------------------------------|---|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7014 BEECH AVE | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE MD
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OVERLEA
d. STREET ADDRESS 7014 BEECH AVE
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) CHRISTOPHER J. KLINGENBERG | | | | | | 4. DATE OF DEATH Feb. 1 1967 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH NOV 27 1896 | | 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE MANAGER K&C. | | | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME ADAM KLINGENBERG | | | | | | 14. MOTHER'S MAIDEN NAME ANNA ? | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO. 722-09-3194 | | 17. INFORMANT MARGARET J. KLINGENBERG 7014 BEECH AVE | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertensive arteriosclerosis
(c) left cordia vascular disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 19 1967 to Feb 1 1967 , that (I) (we) last saw the deceased alive on Jan 19 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Richard R. Rigler | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD R. RIGLER | | | | | | 22d. ADDRESS 1 W. Overlea Ave BALTO 6 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 2/4/67 | | 23c. NAME OF CEMETERY OR CREMATORY PARK WOOD | | 23d. LOCATION (City, town or county) (State) TAYLOR AVE BALTO. MD | | | | |
| 24. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR RD | | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01856 CERTIFICATE OF DEATH 01852

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Halethorpe</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Halethorpe</u> | |
| c. LENGTH OF STAY IN 1b
<u>4 yrs</u> | | d. STREET ADDRESS
<u>5744 First Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>5744 First Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Carroll R. Koehler</u> | | 4. DATE OF DEATH
Month Day Year
<u>February 1 1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1/1/17</u> |
| 9. AGE (In years last birthday)
<u>50</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Technologist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Dental</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George W. Koehler</u> | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Reichert</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>W. W. II 217-01-638</u> | |
| 17. INFORMANT
<u>Mabel R. Koehler</u> | | Address
<u>5744 First Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>592X</u>
DUE TO (b) <u>uremia due to chronic glomerular nephritis</u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov.</u> , 19 <u>66</u> , to <u>1 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1 Feb</u> 19 <u>67</u> , and that death occurred at <u></u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>William J. Bryson</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William J. Bryson</u> | | 22d. ADDRESS
<u>4605 Edmondson Ave.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/4/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Landon Park Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Amrose Jan</u> | | 25a. REC'D BY REGISTRAR
<u>FFB 6</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>1328 Sulphur Spring Rd.</u> | | DATE <u>1967</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G586 2/21/67 mn

CERTIFICATE OF DEATH

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| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN TB | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE / Baltimore 21227 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOUSE IN THE PINES NURSING HOME | | d. STREET ADDRESS 16 EUSTING AVE.
HOUSE IN THE PINE NURSING HOME | |
| 3. NAME OF DECEASED
(Type or print)
First EMORY Middle H. Last KOHLHAUS | | 4. DATE OF DEATH
Month FEB. Day 16 Year 19 67 | |
| 5. SEX MALE
M. REMAKE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/12/91 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
CHARLES E. KOHLHAUS | | 14. MOTHER'S MAIDEN NAME
MINNIE E. HIGH | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
212 05 5531 | |
| 17. INFORMANT
CHARLES E. KOHLHAUS | | Address
5537 OREGON AVE. 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage, recurrent
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic C V D
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5/28/1961 to 2/16 , 19 67 , that (I) (we) last saw the deceased alive on 2/15 , 19 67 , and that death occurred at 2:40 P.M. causes and on the date stated above. | | | |
| 22a. SIGNATURE
Herbert J. Levickas | | 22b. DATE SIGNED
2/17/67 | 22c. PHYSICIAN'S NAME (Type)
HERBERT J. LEVICKAS |
| 22d. ADDRESS
1073 MAIDEN CHOICE LAND 21229 | | 22e. REC'D BY REGISTRAR
2/17/67 | |
| 22f. REGISTRAR'S SIGNATURE
Charles Judge | | 22g. DATE
FEB 20 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/20/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTO., MD. | |
| 24. FUNERAL DIRECTOR
HOWARD H. HUBBARD | | ADDRESS
4107 WILKENS AVE. 21229 | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | c. LENGTH OF STAY IN lb
<u>24 hrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>GREATER BALTIMORE Medical Center</u> | | e. STREET ADDRESS
<u>1819 Cromwood Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>HAZEL</u> First <u>M.</u> Middle <u>KRATZ</u> Last | | 4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-10-88</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Home maker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Rolfe</u> | | 14. MOTHER'S MAIDEN NAME
<u>Marian Teepie</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Charles I. Kratz</u> | | Address
<u>1819 Cromwood Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>1992 IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX AND LUNG</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>67</u> , to <u>2-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> 19 <u>67</u> , and that death occurred at <u>345 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Mario B. Ines</u> | | 22b. DATE SIGNED
<u>2-24-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MARIO B. INES M.D.</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2/27/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Wm. E. Johnson</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 28 1967</u> | |
| ADDRESS
<u>8521 Loch Raven Blvd.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

01854

OFFICE OF THE ADJUTANT GENERAL

01854

UNITED STATES ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

UNITED STATES ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

UNITED STATES ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01859

CERTIFICATE OF DEATH

01855

| | | | | | | | | | | | | | | | | | |
|---|---|--|---------------------|--|---------------|---|------------------------------------|--|---------------------|--|--------------------------|---------------------------------------|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u>
c. LENGTH OF STAY in lb
<u>27 months</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Forest Haven Nursing Home</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Towson</u>
d. STREET ADDRESS
<u>8138 Loch Raven Blvd</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Margaret</u> Middle <u>M.</u> Last <u>Larkin</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>27</u> , Year <u>1967</u> | | 5. SEX
<u>Female</u> | | | | | | | | | | | | | |
| 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan 16, 1882</u> | | | | | | | | | | | | | |
| 9. AGE (In years last birthday) <u>85</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>?</u> | | | | | | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | | | | | |
| Hours | Min. | | | | | | | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>LUTHER GERRICK</u> | | | | | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
<u>MARY KELLY</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>16. SOCIAL SECURITY NO.</td> <td>17. INFORMANT</td> </tr> <tr> <td></td> <td><u>Forrest Haven Nursing Home</u></td> </tr> </table> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | <u>Forrest Haven Nursing Home</u> | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Severe debilitation</u>
1539 DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of bowel</u>
(a), stating the underlying cause last. DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u> | | | | | | | | | |
| 16. SOCIAL SECURITY NO. | 17. INFORMANT | | | | | | | | | | | | | | | | |
| | <u>Forrest Haven Nursing Home</u> | | | | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <table border="1" style="display: inline-table; width: 100%;"> <tr> <td>20c. TIME OF INJURY</td> <td>20d. INJURY OCCURRED</td> <td>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</td> <td>20f. (City or town)</td> <td>(County)</td> <td>(State)</td> </tr> <tr> <td>Month, Day, Year
Hour a.m.
p.m.</td> <td>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> | | 20c. TIME OF INJURY | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | Month, Day, Year
Hour a.m.
p.m. | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | |
| 20c. TIME OF INJURY | 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | | | | | | | | | | | |
| Month, Day, Year
Hour a.m.
p.m. | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| 21. I certify that (this hospital) attended the deceased from <u>Nov 16, 1964</u> to <u>Feb 27, 1967</u> , that (we) last saw the deceased alive on <u>Feb 27, 1967</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above. <table border="1" style="display: inline-table; width: 100%;"> <tr> <td>22a. SIGNATURE
<u>John J. Conroy, M.D.</u></td> <td>22b. DATE SIGNED
<u>2/27/67</u></td> </tr> <tr> <td>22c. PHYSICIAN'S NAME (Type)</td> <td>22d. ADDRESS</td> </tr> <tr> <td><u>John J. Conroy, M.D.</u></td> <td><u>5800 Edmonson Ave</u></td> </tr> </table> | | | | | | 22a. SIGNATURE
<u>John J. Conroy, M.D.</u> | 22b. DATE SIGNED
<u>2/27/67</u> | 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS | <u>John J. Conroy, M.D.</u> | <u>5800 Edmonson Ave</u> | | | | | | |
| 22a. SIGNATURE
<u>John J. Conroy, M.D.</u> | 22b. DATE SIGNED
<u>2/27/67</u> | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS | | | | | | | | | | | | | | | | |
| <u>John J. Conroy, M.D.</u> | <u>5800 Edmonson Ave</u> | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/2/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cemetery</u> | | | | | | | | | | | | | |
| 23d. LOCATION (City, town or county)
<u>Baltimore, Maryland</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Fickman & Sons</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 28 1967</u> | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25c. ADDRESS
<u>Baltimore, Md.</u> | | | | | | | | | | | | | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

VR A15
15M

01832

01832

01832

01832

01832

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01860

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01856

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pikesville 8 | | c. LENGTH OF STAY IN 1b
8 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Milford Mill Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle Alexander Last Lau | | 4. DATE OF DEATH
Month Feb. Day 15 Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 26, 1934 |
| 9. AGE (In years lost birthday) yrs.
32 | | 10. IF UNDER 1 YEAR
Months 32 Days 32 Hours 32 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Co., Md. | |
| 11. BIRTHPLACE (State or foreign country)
Balto. Co., Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
J. Harry Lau | | 14. MOTHER'S MAIDEN NAME
Ruth Eaton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215-30-0715 | |
| 17. INFORMANT
Mrs. Dorothy Lau, Rocklyn & Milford Mill Rd. Pikesville 8 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound left side of neck & face
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Interval between onset and death
instant | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased shot himself with a 12 gauge shotgun. | |
| 20c. TIME OF INJURY Month, Day, Year
9:52 p.m. Feb. 15 1967 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
pay phone booth | 20f. (City or town) (County) (State)
Pikesville Balto. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples M.D. | | 22. DATE SIGNED
2-17-67 | |
| EXAMINER'S NAME (Type)
D. D. Caples, M. D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2-18-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Meadow Branch Cemetery Westminster, Maryland | 23d. LOCATION (City or Town) (County) (State)
Westminster, Maryland |
| 24a. FUNERAL DIRECTOR
Ellsworth Armacost, 4600 Liberty Hts. Ave. Baltimore 21207 | | 25a. REC'D BY REGISTRAR
FEB 17 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

01850

01850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01861

CERTIFICATE OF DEATH

01857

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital | | d. STREET ADDRESS 4311 Woodlea Ave | |
| 3. NAME OF DECEASED (Type or print)
First Theodore Middle W. Last LE BRAND | | 4. DATE OF DEATH February 6 19 67 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 13, 1918 |
| 9. AGE (In years last birthday) 48 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 12. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. FATHER'S NAME Paul J. Le Brand | | 16. MOTHER'S MAIDEN NAME Ida M. Johnson | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 18. SOCIAL SECURITY NO. WW 2 219-03-7930 | |
| 19. INFORMANT Mrs. Ida Le Brand | | Address 4311 Woodlea Ave. | |
| 20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive antero-lateral myocardial infarction.
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
1. Old fibrosed diaphragmatic myocardial infarct. 2. Arteriosclerosis with calcification, coronary arteries. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from February 6, 1967 , to February 6, 1967 , that (X) (we) last saw the deceased alive on February 6, 1967 , and that death occurred at 2:22 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D. | | 22b. DATE SIGNED Feb. 6, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery | | 23d. LOCATION (City or Town) (County) (State) Parkville, Md. | |
| 24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR FEB 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

01823

01823

STATE OF TEXAS

County of _____

City of _____

Know all men by these presents, _____

of the County of _____

State of _____

do hereby certify that _____

is the true and correct _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01862 CERTIFICATE OF DEATH 01858

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2743 Liberty Parkway</u> | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>
d. STREET ADDRESS <u>2743 Liberty Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Levera</u> Middle <u>Pratt</u> Last <u>Lee</u> | | 4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 21, 1878</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Francis M. Pratt</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Axsom</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mr. Henry W. Lee, Sr.</u> Address <u>same address as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1963</u> to <u>107466</u> 1967, that (I) (we) last saw the deceased alive on <u>1-16</u> 1967, and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. J. Fisher</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>2-1-67</u> |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE THEREOF <u>2/1/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Moravian Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Forsythe County, N. C.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Fisher & Sons</u> | | 25a. REC'D BY REGISTRAR <u>Baltimore, Md.</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>FEB 2 1967</u> |

83810

8002

STOVS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|---|--|--|--|---|--|
| 01863 | | | | | | 01859 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 12 | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Armco Nursing Home | | | | | | d. STREET ADDRESS
Guilford Towers Apts. | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Mary Middle Harris Last Lee | | | | | | 4. DATE OF DEATH
Month Feb. Day 8 Year 1967 | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/10/1878 | | 9. AGE (in years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Conklin Harris | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Hamilton Kuhn | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO.
216-46-3741 | | 17. INFORMANT
Mrs. T. H. Marshall Ruxton, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA.
33IX
DUE TO (b) Cerebral Inttherosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
INTERVAL BETWEEN ONSET AND DEATH
48 hrs.
years. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1, 1965 to Feb-8, 1966 , that (I) (we) last saw the deceased alive on Feb-8, 1966 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Dr. Mark Dugan | | | | | | 22b. DATE SIGNED | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Mark Dugan | | | | | | 22d. ADDRESS
15 E. Biddle St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
2/10/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City, town or county) (State)
Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. | | | | | | 25a. REC'D BY REGISTRAR
4905 York Rd. Balto. 12, Md. | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | | |

83810

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01864

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01860

| | | | | | | | |
|---|----------------------------------|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RANDALLSTOWN
c. LENGTH OF STAY in 1b
DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
BALTO. COUNTY GENERAL HOSP. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RANDALLSTOWN WOODLAWN
d. STREET ADDRESS
2117 Gwynn Oak Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Edna Middle G. Last LEIST | | | 4. DATE OF DEATH
Month February Day 19 Year 1967 | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 31, 1877 | 9. AGE (In years lost birthday) yrs.
89 | IF UNDER 1 YEAR
Months 03 Days 1 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
OWN HOME | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
LUTHER D. WEBSTER | | | | |
| 14. MOTHER'S MAIDEN NAME
MARY BLOOM | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | |
| 16. SOCIAL SECURITY NO.
220.44.5585 | | | 17. INFORMANT
Miss MARIE E. LEIST Address Same as #2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
932.7 IMMEDIATE CAUSE (a) Exposure to cold - Associated with
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }
(b) fracture of left radius and contusion -
(c) lacerations of scalp | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Mental confusion incident to senility | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Had wandered out of Nursing Home and apparently slipped on ice | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
5:20 a.m. 2 19 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
Driveway - Nurs. Home | | | |
| 20f. (City or town)
Randallstown | | 20g. (County)
BALTO. | | 20h. (State)
MD. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Russell S. Fisher
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | 22. DATE SIGNED
February 20, 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN | | | |
| 23d. LOCATION (City or Town)
WOODLAWN BALTO. MD. | | 23e. REC'D BY REGISTRAR
FEB 21 1967 | | 23f. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| 24. FUNERAL DIRECTOR
J.T. STANSBURY 6411 WINDSOR MILL RD. | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When possible remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01865

CERTIFICATE OF DEATH

01861

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE (21204) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
GREATER BALTIMORE MEDICAL CENTER | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN First FITZHUGH Middle LEONARD Last | | 4. DATE OF DEATH FEB. 26 19 67 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE CAUC. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-11-12 54 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUILDING MATERIALS | | 10b. KIND OF BUSINESS OR INDUSTRY (President) | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME IRA FITZHUGH LEONARD | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXX Henrietta Wolle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO. 212-05-8639 | |
| 17. INFORMANT Mrs. Katherine Leonard Address (Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
163X IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 16 , 19 67 , to Feb 26 , 19 67 , that (I) (we) last saw the deceased alive on Feb 26 , 19 67 , and that death occurred at 1:25 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE C. C. SHIFF | | 22b. DATE SIGNED Feb 26, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) C. C. SHIFF M.D. | | 22d. ADDRESS 6701 N Charles St. GBMC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 3/1/67. | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cem. | 23d. LOCATION (City or Town) (County) (State) Elkridge, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS | | 25a. REC'D BY REGISTRAR FEB 27 1967 DATE | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

13810

COPIES OF DEEDS

13810

(Inhabitant)

For a further description of

(see)

referred to in the

of

DEEDS OF THE STATE OF NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 items 8,9 Film G386 2/27/67 mh
CERTIFICATE OF DEATH

01866

01862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
20 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS
409 S. AUGUSTA AVENUE | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle J. Last LEONARD | | 4. DATE OF DEATH
Month FEBRUARY Day 16 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12/2/24 1923 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Trucking Co</i> | 9. AGE (In years last birthday) yrs.
43 1/2 |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM J. LEONARD | | 14. MOTHER'S MAIDEN NAME
WINFRED ADAMS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
219 10 05 54 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
13 MONTHS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that this this hospital attended the deceased from 1/27/67 , 19____, to 2/16/67 , 19____, that he (we) last saw the deceased alive on 2/16/67 , 19____, and that death occurred at 10:25AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>George C. McElpatrick M.D.</i> | | 22b. DATE SIGNED
2/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE C. MC ELPATRICK, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2-20-67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
<i>John J. Cowan & Son Inc</i> | | 25a. REC'D BY REGISTRAR
FEB 20 1967 | |
| ADDRESS
<i>Balto Md</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01867

CERTIFICATE OF DEATH

01863

| | | | |
|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Hancock</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>13-2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Balto. Med. Center</u> | | d. STREET ADDRESS
<u>110 Chesapeake Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Gladys Elizabeth Lett</u> | | 4. DATE OF DEATH
<u>2/3/67</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-11-05</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Ernest Ritter</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bonnie Bowers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>NA</u> | |
| 17. INFORMANT
<u>Harry Lett Laurel Md</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastases of pancreatic carcinoma</u>
<u>157X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pancreatic carcinoma</u> DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/11/67</u> , 19 <u>67</u> , to <u>2/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>67</u> , and that death occurred at <u>9 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Juan L. Roque</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JUAN L. ROQUE</u> | | 22d. ADDRESS
<u>68 MC Baltimore MD 21204</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>Feb 5 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Luke's Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore - Carroll - Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Charles J. Jones</u> | | 25a. READ BY REGISTRAR
DATE <u>FEB 15 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01883

01883

Photograph of domestic animals
domestic animals

1/11/11 2/3 2/3 2/3

2/3 2/3

Baltimore MD 21204

88 MC

JUAN L. ROQUE

from 1. Roque

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01868

CERTIFICATE OF DEATH

01864

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN 1b
Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Adam A. Middle Lozanski Last Lozanski | | 4. DATE OF DEATH
Month February Day 9 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1909 Dec. 24 1909* |
| 9. AGE (In years last birthday) yrs. 57 | | 10. IF UNDER 1 YEAR
Months 57 Days 57 Hours 57 Min. 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed | | 10b. KIND OF BUSINESS OR INDUSTRY
Mechanic | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WALTER LOZANSKI | | 14. MOTHER'S MAIDEN NAME
BOBBINNA STAFANSKI | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
213 03 4239 | |
| 17. INFORMANT
Mrs. Helen C. Lozanski - 2418 Orleans St. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Lung with Brain Metastasis
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 21 , 19 67 , to Feb. 9 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 9 , 19 67 , and that death occurred at 6PM. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Joel V. Tolentine | | 22b. DATE SIGNED
Feb. 9 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Joel V. Tolentine | | 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-13-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | |
| 24. FUNERAL DIRECTOR
Partly Miller - 2334 Jefferson St. | | 25a. REC'D BY REGISTRAR
DATE FEB 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|---------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
BALTIMORE | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
GREATER BALTIMORE MED. CENTER | | d. STREET ADDRESS
711 N. MONTFORD AVE. | |
| 3. NAME OF DECEASED
(Type or print)
GEORGE LEO LOGUE, SR. | | 4. DATE OF DEATH
Month FEBRUARY Day 2 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
CAU. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-01-09 |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months 57 Days 2 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FIREMAN - BALTO CITY | | 10b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MARYLAND | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
FELIX LOGUE | | 14. MOTHER'S MAIDEN NAME
CARRIE S. SCHAEFER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-01-5022 | |
| 17. INFIRMANT
Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 201X
Respiratory failure
DUE TO
Bronchopneumonia.
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
Hodgkin's Disease. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Irradiation Ulcer chest & Back. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-26, 1965 , to 2-2, 1967 , that (I) (we) last saw the deceased alive on 2-2, 1967 , and that death occurred at 6:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
2/2/67 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/6/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Schimunek Funeral Home, Inc. | | 25a. REC'D BY REGISTRAR
DATE 6 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S SIGNATURE
[Signature] | |

01863

01863

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01870

CERTIFICATE OF DEATH

01866

| | | | |
|---|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson 4 | | c. LENGTH OF STAY IN 1b
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph's Hospital | | d. STREET ADDRESS
6211 Marietta Ave. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle F. Last LOSCH | | 4. DATE OF DEATH
Month February Day 18 Year 1967 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/15/72 |
| 9. AGE (In years last birthday)
94 yrs. | | IF UNDER 1 YEAR
Months 94 Days 94 Hours 94 Min. 94 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 11. BIRTHPLACE (County & State, or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? Losch | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-07-0117 | |
| 17. INFORMANT
Raymond C. Bussey Sr. (Step-Son) | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 493X
DUE TO cerebral thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal pneumonia
DUE TO (c) --- | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 15 , 19 67 , to Feb 18 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 18 , 19 67 , and that death occurred at 9P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Fiorello G. Malit | | 22b. DATE SIGNED
2-18-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Fiorello G. Malit | | 22d. ADDRESS
7620 York Road, Baltimore 21204, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb. 21, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Salladasburg Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Salladasburg Penna. | |
| 24. FUNERAL DIRECTOR
Eugenia K. Seitz
Seitz Funeral Home | | 25. REC'D BY REGISTRAR
FEB 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

018810

018810

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT OF THE

COMMISSIONER OF

THE LAND OFFICE

AND

OF THE

LAND OFFICE

AND

IN SENATE

January 1, 1901

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01871

01867

| | | | | | |
|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Summit Nursing Home | | | d. STREET ADDRESS
617 Aldershot Road 21229 | | |
| 3. NAME OF DECEASED (Type or print)
First Raymond Middle H. Last Lyeth | | | 4. DATE OF DEATH
Month February Day 13 Year 1967 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 28, 1885 | 9. AGE (In years last birthday)
81 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Contract Carrier | | 10b. KIND OF BUSINESS OR INDUSTRY
Self | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME
Samuel Lyeth | | | 14. MOTHER'S MAIDEN NAME
Catherine | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-01-1218 | 17. INFORMANT
Mrs. Mollie Lyeth same address as above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Decompensation
4221 DUE TO
(b) Arteriosclerotic Cardio-Vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 wks.
6 wks. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-14, 1963 to 2-13, 1967 , that (I) (we) last saw the deceased alive on 2-10, 1967 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Wilmer K. Gallagher Jr. | | 22b. DATE SIGNED
2-13-67 | 22c. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher Jr. | | |
| 22d. ADDRESS
6209 Frederick Ave. Baltimore 28 Md. | | 22e. REC'D BY REGISTRAR
FEB 14 1967 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/15/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | 23d. LOCATION (City, town or county) (State)
Woodlawn, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tinkner | | 25. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01807

CERTIFICATE OF DEATH

01807

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

AGE AT DEATH

SEX

SEX

RACE

RACE

EDUCATION

EDUCATION

RELIGION

RELIGION

MARRIAGE

MARRIAGE

CHILDREN

CHILDREN

PROPERTY

PROPERTY

DEBTS

DEBTS

TESTAMENTARY

TESTAMENTARY

WILLS

WILLS

ADMINISTRATION

ADMINISTRATION

EXECUTORS

EXECUTORS

ADMINISTRATORS

ADMINISTRATORS

RECEIPTS

RECEIPTS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/66

01872

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01868

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
4 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS
1815 BARCLAY STREET | |
| 3. NAME OF DECEASED
(Type or print)
First ARTHUR Middle D. Last MADDEN | | 4. DATE OF DEATH
Month FEBRUARY Day 24 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/24/21 |
| 9. AGE (In years last birthday) yrs.
45 | | 10. IF UNDER 1 YEAR
Months 19 Days 67 | |
| 11a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired)
LABORER | | 11b. KIND OF BUSINESS OR INDUSTRY
ODD JOBS | |
| 11. BIRTHPLACE (State or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOSEPH MADDEN | | 14. MOTHER'S MAIDEN NAME
FANNIE HUNTER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
212 14 35 54 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 9000 FRACTURE CERVICAL SPINE C5
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
32 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
FALL DOWN STAIRS | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 1/23/ p.m. 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Baltimore, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M. B. Davis | | 22. DATE SIGNED
2/24/67 | |
| EXAMINER'S NAME (Type)
MELVIN B. DAVIS, M. D. | | 6800 Mornington Rd., Balto., Md. 21222 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3-1-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
RAYNER SANDERS | | ADDRESS
FUNERAL HOME, 217 E. Preston Street, Baltimore | |
| 25a. REC'D BY REGISTRAR
DATE FEB 28 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

01882

01882

MAINTENANCE

REPAIRS

WORK ORDER

WORK ORDER

DATE

TIME

TIME

BY

BY

BY

DESCRIPTION

DESCRIPTION

DESCRIPTION

REMARKS

REMARKS

WORK ORDER

WORK ORDER

DATE

TIME

WORK ORDER

WORK ORDER

WORK ORDER

WORK ORDER

WORK ORDER

WORK ORDER

WORK ORDER

WORK ORDER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 01873 Item #7 Film #G388 5/2/67, DC 01869
 CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore County | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles Co. | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mount Wilson | | | | c. LENGTH OF STAY IN 1b
7 mo | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Nanjemoy (Rural) 08-2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Mount Wilson State Hospital | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Earl | | First | | Middle
— | | Last
Maddox | | 4. DATE OF DEATH
Month 2 Day 6 Year 1967 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
3-22-02 | | 9. AGE (In years last birthday)
64 yrs. | | IF UNOER 1 YEAR Months Days Hours Min.
IF UNOER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Rigger | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S.N.P.P. | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | | |
| 13. FATHER'S NAME
Henry Maddox | | | | | | 14. MOTHER'S MAIDEN NAME
Maria Posey | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
216-32-9753 | | 17. INFORMANT Address
Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma
1621 DUE TO metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621 (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Minimal Pulmonary Tuberculosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 mo. | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-14-1966 , to 2-6-1967 , that (I) (we) last saw the deceased alive on 2-6-1967 , and that death occurred at 12²⁵ M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Wm. Newcomer | | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-6-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D., Superintendent | | | | | | 22d. ADDRESS
Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb. 9, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Nanjemoy Baptist | | 23d. LOCATION (City, town or county) (State)
Nanjemoy, Charles, Md. | | | | | |
| 24. FUNERAL DIRECTOR
Archibald Funeral Home La Plata, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 16 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01804

01878

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

4 mo.

Thymopexin Calcium
5 tablets

Minimal Pulmonary Tuberculosis

Dr. Newcomb, H.D., Superintendent, Mount Wilson, Maryland

Feb. 9, 1957, Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01874

CERTIFICATE OF DEATH

01870

| | | | |
|--|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN 1b
Baltimore 21204 031 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
I674 Mussula Rd. | |
| 3. NAME OF DECEASED (Type or print)
First Baby Girl Middle Malthan Last Malthan | | 4. DATE OF DEATH
Month February Day 4 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/3/67 |
| 9. AGE (In years last birthday) yrs.
23 | | IF UNDER 1 YEAR
Months 23 Days 23 Min. 23 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Charles D. Malthan | | 14. MOTHER'S MAIDEN NAME
Eleanor R. Clary | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Parents | | Address
same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 776X
DUE TO (b) Immaturity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Immaturity
DUE TO (c) Immaturity | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 3 , 19 67 , to Feb. 4 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 4 , 19 67 , and that death occurred at 9:25 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Jose S. Aguto | | 22b. DATE SIGNED
Feb. 4 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Jose S. Aguto | | 22d. ADDRESS
6720 York Rd. Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/6/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE FEB 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01870

01870

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>3204 Woodvalley Drive #8</u> | | | | d. STREET ADDRESS
<u>3204 Woodvalley Drive #8</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Jack L. Mazer</u> Middle Last | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>9</u> Year <u>19 67</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 6, 1916</u> | |
| 9. AGE (In years last birthday)
<u>50</u> yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Merchant</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retail</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Abraham Mazer</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Bessie Horwitz</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>W. W. 11</u> <u>Army</u> | | | | 16. SOCIAL SECURITY NO.
<u>216-09-1695</u> | | 17. INFORMANT
<u>Mrs. Frances Mazer, 3204 Woodvalley Drive #8</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO (b) <u>Coronary occ</u>
DUE TO (c) <u>ASCVD</u>
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-19-66</u> to <u>2-9-1967</u> , that (I) (we) last saw the deceased alive on <u>2-9-1967</u> and that death occurred at <u>2:30</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Jerome S. Collier MD</u> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
<u>Jerome S. Collier MD</u> | |
| 22d. ADDRESS
<u>2217 South Rd</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/10/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Beth Tfiloh</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | | | | 25a. REC'D BY REGISTRAR
<u>FEB 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

01873

CERTIFICATE OF DEATH

01873

MAINTAIN THE DEPARTMENT OF HEALTH
HOSPITAL AND CLINICAL RECORDS - ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED DATE 01-11-2011 BY 60322

NAME: JAMES A. JONES
DATE OF BIRTH: 1915
PLACE OF BIRTH: [illegible]
DATE OF DEATH: 1973
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
REGISTRATION NO.: 11-00-1992

CHIEF CLERK

MADE IN
EX-1001

Set. General & Co., Inc., 1015 Washington St., Boston, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

01875

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01871

| | | | | |
|--|----------------------------------|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto. Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Upperco</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Black Rock Rd.</u> | | d. STREET ADDRESS
<u>Black Rock Rd.</u> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Bertie</u> Middle <u>J.</u> Last <u>Martin</u> | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>5,</u> Year <u>19 67</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 31, 1882</u> | |
| 9. AGE (In years last birthday)
<u>84</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Co.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | |
| 13. FATHER'S NAME
<u>Joshua Armacost</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Thompson</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>217-48-1516</u> | | |
| 17. INFORMANT
<u>Mrs. Helen Bentz</u> | | Address
<u>Upperco, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>
<u>4221</u>
DUE TO <u>Arteriosclerotic Cardio Vascular Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u>
DUE TO (c) <u> </u> | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u> </u> | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
<u> </u> | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 26,</u> 19 <u>62</u> , to <u>Feb. 5,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3,</u> 19 <u>67</u> , and that death occurred at <u>1</u> A.M. from the causes and on the date stated above. | | | | |
| 22a. SIGNATURE
<u>Joseph E. Bush M.D.</u> | | 22b. DATE SIGNED
<u>2/6/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Joseph E. Bush M.D.</u> | | 22d. ADDRESS
<u>117 S. Main Street Hampstead, Md.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 8, 1967</u> | | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Grace Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Upperco Balto. Co.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Tipton-Eline Funeral Home Hampstead, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 8 1967</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

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Journal of Management Education

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MD

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01876

CERTIFICATE OF DEATH

01872

| | | | |
|--|------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore, MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
College Manor Nursing Home | | d. STREET ADDRESS
321 Taplow Road | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Miss. Pauline Regina Mathaney | | 4. DATE OF DEATH
Month Day Year
February 14th. 19 67 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/12/1881 |
| 9. AGE (In years last birthday)
85 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired- Buyer | | 10b. KIND OF BUSINESS OR INDUSTRY
Stewart & Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William F. Mathaney | | 14. MOTHER'S MAIDEN NAME
Amanda Melvin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-03-2504 | |
| 17. INFORMANT
Howland S. Roberts, Sr. | | Address
(Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
237X IMMEDIATE CAUSE (a) TUMOR
DUE TO (b) CEREBRI
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
NONE | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
NONE | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1966 , to Feb 14, 1967 , that (I) (we) last saw the deceased alive on Feb 13, 1967 , and that death occurred at 11:10 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. A. S. Chalfant | | 22b. DATE SIGNED
Feb 14 67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. A. S. Chalfant | | 22d. ADDRESS
6210 York Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/16/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Road | | 25a. REC'D BY REGISTRAR
FEB 15 1967 | |
| ADDRESS
Baltimore 12, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01877

CERTIFICATE OF DEATH

01873

| | | | | | | | |
|--|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Summit Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Arbutus
d. STREET ADDRESS
1232 Maiden Choice Lane
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Pauline K. Matthiesen | | | 4. DATE OF DEATH Month Day Year
February 26, 1967 | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
7-4-1890 | | 9. AGE (In years last birthday)
76 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY

 | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 13. FATHER'S NAME
Ferdinand Krahn | | | 14. MOTHER'S MAIDEN NAME
Katherina Snyder | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Choice Lane
Mr. Frederick W. Matthiesen, 1232 Maiden | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5271 Super-tensio A. SCVD
DUE TO (b) Grade IV Congestive Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Emp Hysemum (Severe) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Bronchitis | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Jan, 1967 to 2/26, 1967, that (I) (we) last saw the deceased alive on 2/25 1967, and that death occurred at 9:30 A.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Dr. John C. Healy | | | 22b. DATE SIGNED
2/27/67 | | 22c. PHYSICIAN'S NAME (Type)
Dr. John C. Healy | | |
| 22d. ADDRESS
1311 Francis Ave. Balto, Md. 21227 | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
BURIAL | | 23b. DATE THEREOF
3-1-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR ADDRESS
HOWARD H. HUBBARD, 4107 Wilkens Ave. 21229 | | | | | |
| 25a. REC'D BY REGISTRAR
DATE MAR 1 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01873

STATEMENT OF DEBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01878

CERTIFICATE OF DEATH

01874

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
Timonium, Maryland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | d. STREET ADDRESS
204 Ridgley Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Grace V. Mayes | | 4. DATE OF DEATH
Month February Day 13 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-23-27 |
| 9. AGE (In years lost birthday) yrs.
39 | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John M. Galloway | | 14. MOTHER'S MAIDEN NAME
Grace B. Budnitz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-24-0010 | |
| 17. INFORMANT
Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) epilepsy - status epilepticus
345X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple sclerosis
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-7-66 , 19__, to 2-13-67 , 19__, that (I) (we) lost the deceased alive on 2-13-67 , 19__, and that death occurred at 2:20 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stella Wachslar | | 22b. DATE SIGNED
2/13/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/15/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park Cem | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto. | | 25a. REC'D BY REGISTRAR
FEB 16 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01874

Wash

Washington

Washington, D.C.

John M. Schaefer

February 13 67

Wash

Wash

Wash

2-23-67

White

White

U.S.A.

Kentland

John M. Schaefer

John M. Schaefer

Records: Series Grove State Hospital

2-23-67

2-7-66

2-23-67

John M. Schaefer, M.D.

Feb 14 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 5-63

| <div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>01880</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>01876</p> </div> </div> | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b 3 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Presbyterian Home of Md. | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
e. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS Hopkins Apts.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) Clare B. McCance | | | | | 4. DATE OF DEATH
Month Feb. Day 18, Year 1967 | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 30, 1881 | | 9. AGE (In years last birthday) 86
IF UNDER 1 YEAR: Months 0 Days 0
IF UNDER 24 HRS.: Hours 0 Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Will Brothers | | | | | 14. MOTHER'S MAIDEN NAME
Nellie Waddington | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
(If give year or dates of service) | | 17. INFORMANT
Records of Presbyterian Home of Md. | | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
minutes
years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Abemia etiology undetermined | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (M.D.) attended the deceased from 6-4-66 , 19 66 , to 2-18-67 , 19 67 , that (I) (M.D.) last saw the deceased alive on 2-15-1967 , and that death occurred at 1 P.M. from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
S.J. Venable, Jr. M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-18-67 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS
7215 York Road, Baltimore, Md 21212 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-21-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION (City, town or county) (State)
Woodlawn, Maryland | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Mitchell-Wiedefeld Home, Inc.
6500 York Road Baltimore, Md. | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
FEB 24 1967 | | |

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McNamee

James V

James

James V

James V

James V

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|--|--|--|--|
| 01881 | | Item 3 Film G385 | | 2/15/67 | | 01877 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN lb 18 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GLEN ARM, MARYLAND
d. STREET ADDRESS Box 660 HARFORD ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First DOROTHY Middle McCarthy Last ELAINE MCCARTHY | | | | 4. DATE OF DEATH
Month FEBRUARY Day 10 Year 1967 | | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-27-1915 | | 9. AGE (in years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME ERNEST E. STANSBURY | | | | 14. MOTHER'S MAIDEN NAME ANNA GUYER | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT SON | | Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
416X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RHEUMATIC HEART DISEASE
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos.
32+ YRS. | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-9- , 19 67 , to 2-10- , 19 67 , that (I) (we) last saw the deceased alive on 2-10- 19 67 , and that death occurred at 11:15 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<i>E. K. S. Narayanan</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
2-10-1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) E. K. S. NARAYANAN, M.D. | | | | 22d. ADDRESS
GREATER BALTIMORE MED. CENTER, MD. 21204 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2-13-67 | | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK. CEM | | 23d. LOCATION (City, town or county) (State) Bk/Ho MD. | | | | | |
| 24. FUNERAL DIRECTOR
CHAS. T. EVANS & SON | | | | ADDRESS 8802 Harford Rd | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |
| | | | | | | DATE FEB 14 1967 | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01882

01878

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md
b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN TB | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Summit Nursing Home | | d. STREET ADDRESS
331 Washburn Ave | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle T Last McClellan | | 4. DATE OF DEATH
Month Feb Day 27 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec 28, 1885 |
| 9. AGE (In years lost birthday)
81 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Hoffmann | | 14. MOTHER'S MAIDEN NAME
Unk | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Family | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease
410X DUE TO Rheumatic Heart Disease with Aortic & Mitral Insufficiency & Aortic & Pulmonary Stenosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial Infarction
(c) Pulmonary Embolism | | | INTERVAL BETWEEN ONSET AND DEATH
10 yrs
50 yrs
6 wks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Alcoholism | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2/23/67 , to 2/27/67 that (I) two saw the deceased alive on 2/28/67 and that death occurred at 7:00A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
W E McGrath M.D. | | 22b. DATE SIGNED
2/28/67 | 22c. PHYSICIAN'S NAME (Type)
W E McGrath M.D. |
| 22d. ADDRESS
1303 Frederick Rd | | 22e. ADDRESS
1303 Frederick Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
3/2/67 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md |
| 24. FUNERAL DIRECTOR
McCully F H 237 Patapsco Ave 21225 | | 25a. REC'D BY REGISTRAR
DATE MAR 1 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01883

CERTIFICATE OF DEATH

01879

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN lb
7 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | | d. STREET ADDRESS
3437 Edmondson Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Derrick Leroy McCloud | | | | 4. DATE OF DEATH
Month Day Year
2 16 19 67 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11-20-55 | |
| 9. AGE (In years last birthday)
11 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
none | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
Walter Osborne | | | |
| 14. MOTHER'S MAIDEN NAME
Annette McCloud | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no -- | | | |
| 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Address
Rosewood State Hosp., Owings Mills, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Congestion & edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral edema
DUE TO
(c) Undetermined | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
terminal hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 8-6 , 19 59 , to 2-16 , 19 67 , that (X) (we) last saw the deceased alive on 2-16 , 19 67 , and that death occurred at 10:12 , home and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Richard A. Jones | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
17 Feb 67 | |
| 22c. PHYSICIAN'S NAME (Type)
Richard A. Jones | | | | 22d. ADDRESS
Rosewood State Hosp. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rosewood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 27 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED
JAN 10 1967
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE
FROM: [illegible]
SUBJECT: [illegible]

Enclosed for the Director are two copies of a report
entitled "Cerebral Lesions in the Rat"
by [illegible]

The report was prepared by [illegible]
and [illegible] of the [illegible]
Laboratory, Agricultural Research Service, [illegible]

Very truly yours,
[Signature]
[Name]

177-67
Rosewood State Hosp.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

01884

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01880

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
a. STATE MD b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 2 1/2 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8200 CARRBRIDGE CIRCLE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOHN STANLEY McCOLLOUGH | | 4. DATE OF DEATH FEB 1 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-6-24 |
| 9. AGE (In years lost birthday) 43 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager | | 10b. KIND OF BUSINESS OR INDUSTRY A.O. Smith Corp. | |
| 11. BIRTHPLACE (State or foreign country) Lancaster Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Huston McCollough | | 14. MOTHER'S MAIDEN NAME Edythe Johns | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWII | | 16. SOCIAL SECURITY NO. 197-07-9173 | |
| 17. INFORMANT Mrs Julie Stanley McCollough | | Address 8200 Carrbridge Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT
445X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT HYPERTENSION DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 7 YRS. |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE William A. Pillsbury M.D. | | 22. DATE SIGNED 2-1-67 | |
| EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Towson, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/3/67 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery | 23d. LOCATION (City or Town) (County) (State) Timonium, Maryland |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks | | ADDRESS Towson 1050 York Rd. 21204 | |
| 25a. REC'D BY REGISTRAR FEB 6 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01885

CERTIFICATE OF DEATH

01881

| | | | | | | | |
|--|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
2mthldy | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
1219 Fayette Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Aldine Middle D. Last McCullough | | | | 4. DATE OF DEATH
Month February Day 2 Year 1967 | | | |
| 5. SEX
female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 16, 1897 | | 9. AGE (In years last birthday) yrs.
69 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Daniel Townsend | | | | 14. MOTHER'S MAIDEN NAME
Emily | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR HT. DIS.
DUE TO
(c) ARTERIOSCLEROSIS, GENERALIZED | | | | | | INTERVAL BETWEEN ONSET AND DEATH
ACUTE
10 yrs.
10 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 1, 1966 to Feb. 2, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 2, 1967 , and that death occurred at 11:00 P., from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Anthony J. Young</i> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | |
| 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/9/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md | |
| 24. FUNERAL DIRECTOR
Adolphus Halstead | | | | 25a. REC'D BY REGISTRAR
DATE FEB 10 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01882

| | | | | | | | |
|--|-------------------------------|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND
c. LENGTH OF STAY IN 1b 23 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 30.4
d. STREET ADDRESS 804 W. PRATT STREET
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First CONLEY Middle W. Last MC GIMPSEY | | 4. DATE OF DEATH
Month FEBRUARY Day 5 Year 19 67 | | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 3, 1891 75 yrs. | 9. AGE (In years last birthday) 75 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK | | 10b. KIND OF BUSINESS OR INDUSTRY AMUSEMENT MACHINE CO. | | 11. BIRTHPLACE (County & State, or foreign country) MORGANTON, N. C. | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM MC GIMPSEY | | 14. MOTHER'S MAIDEN NAME ADA CONLEY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW I 217 16 31 05 | | 17. INFORMANT Address Mr. Richard G. Lissau-804 W. Pratt St. CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA OF RIGHT LUNG WITH METASTASES TO REGIONAL LYMPH NODES
DUE TO (b) 16.21
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that NO (this hospital) attended the deceased from 1/13/67 , 19__, to 2/5/67 , 19__, that we last saw the deceased alive on 2/5/67 , 19__, and that death occurred at 8:00 a.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Sheldon E. Kalmutz | | | | 22b. DATE SIGNED 2/7/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) SHELDON E. KALMUTZ, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2-9-67 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | | |
| 23d. LOCATION (City, town or county) (State) BALTIMORE, MD. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| ADDRESS WITZKE FUNERAL HOME | | DATE FEB 9 1967 | | | | | |
| BALTIMORE, MD. | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01887

CERTIFICATE OF DEATH

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| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN lb
129 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE, # DUNDALK 21222 13-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
3304 CORNWALL ROAD | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
ELMER -- MC KENNA | | | | 4. DATE OF DEATH Month Day Year
FEBRUARY 18 19 67 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DEC. 6, 1914 | |
| 9. AGE (In years last birthday)
52 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Observer- Steel Mfr. Metalurigic. | | 10b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE, MARYLAND | | 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
JOSEPH MC KENNA | | | |
| 14. MOTHER'S MAIDEN NAME
GERTRUDE LERCH | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW-11 | | | |
| 16. SOCIAL SECURITY NO.
215 03 75 01 | | 17. INFORMANT Address
CLIN REC VET ADM HOSP FT HOWARD MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL
199.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA OF GROINS DUE TO
(c) 18 MONTHS | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from OCT. 12 1966 , to FEB. 18 1967 , that (B) (we) last saw the deceased alive on FEB. 18, 1967 , and that death occurred at 1:30 p. M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Attilio A. Ceraldi</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2 18 67 | |
| 22c. PHYSICIAN'S NAME (Type)
ATTILIO A. CERALDI, M. D. | | | | 22d. ADDRESS
VET. ADM. HOSP., FT. HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEEMER CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
<i>Walter Brook Bradley</i>
Walter Brook Bradley
400 Willow Spring Rd.
Baltimore 22, Md. | | | | 25a. REC'D BY REGISTRAR
FEB 23 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson - 4</u> | | c. LENGTH OF STAY IN 1b
 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> | | b. COUNTY <u>-</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Greater Balt. Med Center</u> | | | | | | d. STREET ADDRESS
<u>1195 W. 30th Street Balto</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>HAROLD</u> | | First <u>McVEY</u> | | Middle <u>HMN</u> | | Last <u>McVEY</u> | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>17</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3-29-09</u> | | 9. AGE (In years last birthday)
<u>57</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>unemployed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
 | | 11. BIRTHPLACE (County & State, or foreign country)
 | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Lee McVey</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Hilton</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>400-07-8562</u> | | 17. INFORMANT
<u>Hosp Records</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Hemoptysis</u>
<u>1992</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Tracheo-esophageal fistula Cancer Metastases to Liver</u>
(c) <u>Cancer of the lung, esophagus and trachea</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 6</u>, 19<u>67</u>, to <u>Feb. 17</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>Feb. 17</u>, 19<u>67</u>, and that death occurred at <u>M</u>, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>C. C. Shih</u> | | | | | | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>CHU-CHIN SHIH</u> | | | | 22d. ADDRESS
<u>GREATER BALTIMORE MEDICAL CENTER</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 23b. DATE THEREOF
<u>2/18/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cornett</u> | | 23d. LOCATION (City, town or county) (State)
<u>TOTZ, KY</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Way Jackson & Sons 10000 Balto. Med</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

A2310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 018889 | | | | | 018885 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | | c. LENGTH OF STAY IN 1b
<u>6 YEARS</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE - Parkville 03</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>8549 MORVIN RD., BALTO., MD.</u> | | | | | d. STREET ADDRESS
<u>8549 MORVIN ROAD</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>MARY PATRICIA MEGEE</u> | | | | | 4. DATE OF DEATH
Month Day Year
<u>FEB. 9th 1967</u> | | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3/10/21</u> | | 9. AGE (in years last birthday)
<u>45 yrs.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | | 11. BIRTH PLACE (County & State, or foreign country)
<u>BALTIMORE, MD.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | |
| 13. FATHER'S NAME
<u>MR. RICHARD LEONARD</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MRS. MARGARET FINNEGAN</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | | 17. INFORMANT
<u>MR. GEORGE MEGEE</u> | | Address
<u>(SAME AS ABOVE)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF THE LIVER</u>
<u>5810</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>EPILEPSY</u> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>NONE</u> | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>NONE</u> 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)
<u>NONE</u> | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u>FEB. 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>FEB. 9</u> 19 <u>67</u> , and that death occurred at <u>2:25 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Ruben Sebastian</u> | | | | | 22b. DATE SIGNED
<u>2/9/67</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RUBEN S. SEBASTIAN</u> | | | | | 22d. ADDRESS
<u>308A OLD HARTFORD RD. #34</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb 13 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cem</u> | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore Md</u> | | | |
| 24. FUNERAL DIRECTOR
<u>J. Melville Jenkins 2713 Kirk Ave</u> | | | | | 25a. REC'D BY REGISTRAR
<u>FEB 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Jones</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| | | | | | |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River
c. LENGTH OF STAY IN 1b
Middle River
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ivy Hall Nursing Home | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1307 Gorsuch Ave.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Cora E. Menzel | | | 4. DATE OF DEATH February 2, 19 67 | | |
| 5. SEX Female | | | 6. COLOR OR RACE White | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH June 15, 1893 | | |
| 9. AGE (In years last birthday) 73 yrs. | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Conrad Hohman | | | 14. MOTHER'S MAIDEN NAME Cornelia Speigel | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. Mrs. Virginia Riggins, 2 Branch St. 21221 | | |
| 17. INFORMANT Mrs. Virginia Riggins, 2 Branch St. 21221 | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
1992 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Carcinoma of ovary + colon
(a), stating the underlying cause last. } DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/7 , 19 66 , to 2/1 , 19 67 ; that (I) (we) last saw the deceased alive on 1/28 , 19 67 , and that death occurred at 4 A.M. , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Samuel Stern M.D. | | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) Samuel Stern M.D. | | | 22d. ADDRESS 285 Ridge Road | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Feb. 4, 1967 | | |
| 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home 4210 Belair Road. | | | 25. REC'D BY REGISTRAR FEB 6 1967 | | |
| 25a. REGISTRAR'S SIGNATURE Charles Judge | | | 25b. REGISTRAR'S SIGNATURE | | |

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01891

CERTIFICATE OF DEATH

01887

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO CO.</u> 21212 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Greater Baltimore Medical Center</u> | | d. STREET ADDRESS
<u>8014 Wynbrook Rd.</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Kay Yvonne Meredith</u> | | 4. DATE OF DEATH
Month Day Year
<u>FEB. 20 19 67</u> | |
| 5. SEX
<u>FEMALE CAUC.</u> | 6. COLOR OR RACE
<u>CAUC.</u> | 7. MARRIED <input checked="" type="checkbox"/> <u>NEVER MARRIED</u> <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>6-13-35</u> |
| 9. AGE (In years last birthday)
<u>31</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>SHAMOKIN, PA.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>WILLIAM FRANCIS LYTLE</u> | | 14. MOTHER'S MAIDEN NAME
<u>DOROTHY M AYLORE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>N.A.N.D.</u> | | 16. SOCIAL SECURITY NO.
<u>161-28-7894</u> | |
| 17. INFORMANT
<u>CHAS. TAL. RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
331X DUE TO
(b) <u>Chronic Hypertension</u>
DUE TO
(c) <u>Massive pontine hemorrhage</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hours</u>
<u>13 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (a) (this hospital) attended the deceased from <u>Oct 1966</u> , to <u>Feb 20 1967</u> , that (b) (we) last saw the deceased alive on <u>Feb 20 1967</u> , and that death occurred at <u>6:45 P.M.</u> from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Clifton C. Presser</u> | | 22b. DATE SIGNED
<u>2/20/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Clifton C. Presser</u> | | 22d. ADDRESS
<u>GREATER BALTO. MED. CENTER</u>
<u>101 W. Read St.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Rem. Burial</u> | 23b. DATE THEREOF
<u>2/24/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Odd Fellows</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Shamokin, Pa.</u> |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 23 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01892

Item #6 Film #G385 2/17/67

CERTIFICATE OF DEATH

01888

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
Maryland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21204
d. STREET ADDRESS
617 Charles St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Alice MERRITT | | 4. DATE OF DEATH
Month Day Year
February 11, 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1889 |
| 9. AGE (In years lost birthday) yrs.
77 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (County & State, or foreign country)
Maryland | | 13. CITIZEN OF WHAT COUNTRY? | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Acute myocardial infarction secondary to coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis
(c) Arteriosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 10 (this hospital) attended the deceased from 2/6/ , 19 67 , to 2/11/ , 19 67 that 10 (we) last saw the deceased alive on 2/11/ , 19 67 , and that death occurred at 12:30M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Arturo A. Pidlaoan MD | | 22b. DATE SIGNED
February 11, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Arturo Pidlaoan, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
2-13-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
U. of Md. Med. School | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE | |
| DATE | | FEB 14 1967 | |

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DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|------------------------------|---|---|---|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01893 | | | | | 01893 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY Baltimore | | | | | a. STATE Md b. COUNTY AA Co | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Dulaney Towson Home | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Pasadena | | | | |
| c. LENGTH OF STAY IN 1b | | | | | d. STREET ADDRESS | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Dulaney Towson Home | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First John Middle Thomas Last Metzdorf | | | | | Month Feb Day 20 Year 1967 19 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/13/87 | | 9. AGE (In years last birthday)
80 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sea Food | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Md | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unk | | | | | 14. MOTHER'S MAIDEN NAME
Mary Conaway | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Family | | | Address
Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V disease
DUE TO (c) CA of lung
INTERVAL BETWEEN ONSET AND DEATH
3 days
20 yrs.
? | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/13 , 1967, to Feb. 20 , 1967, that (I) (we) last saw the deceased alive on Feb. 19 , 1967, and that death occurred at 1:50 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Jos. A. Sedlack | | | | | 22b. DATE SIGNED
2/21/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Jos. A. Sedlack | | | | | 22d. ADDRESS
260 W. Preston Ave Towson Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
2/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION (City, town or county) (State)
AA CO Md | | |
| 24. FUNERAL DIRECTOR
McCully F H 237 Patapsco Ave 21225 | | | | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1967 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01894

CERTIFICATE OF DEATH

01890

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>MARYLAND</u> b. COUNTY
<u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN TB
<u>1 year</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Forest Haven Nursing Home</u> | | d. STREET ADDRESS
<u>2909 Berwick Ave</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>ALBERT</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>4</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/20/1888</u> |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Brain Sclerosis - cardiovascular</u>
DUE TO (b) <u>myocardial infarction</u>
DUE TO (c) <u>myocardial infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>67</u> , to <u>2/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>67</u> , and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John H. Shaw M.D.</u> | | 22b. DATE SIGNED
<u>2/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John H. Shaw M.D.</u> | | 22d. ADDRESS
<u>State Department of Health, Baltimore, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2/6/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>A.A. Co. Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>William E. Johnson</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |
| 8521 Loch Raven Blvd. | | DATE <u>FEB 14 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00810

00810 70 70311(1)

00810

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #12 Film #G-185 2/1/67 pc
CERTIFICATE OF DEATH

01895

01891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health.

| | | | | | | | |
|---|-------------------------|--|--|--|--|---|--|
| 1. NAME OF DECEASED
(Type or Print)
Ilona Mihalovich | | | | 2. DATE AND HOUR OF DEATH
2-1-67 12:10a.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND
BALTIMORE COUNTY | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY BALTIMORE COUNTY
C. CITY OR TOWN 627 Adershot Road
D. STREET ADDRESS Baltimore, Maryland 03-1
627 Adershot Road | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION
BALTIMORE - 29
627 Adershot Rd. | | | | | | | |
| 5. SEX
Female | 6. RACE
White | 7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed | | 8. DATE OF BIRTH
3-13-95 | 9. AGE (In years last birthday)
71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Editorial assistant Newspaper | | | | 11. BIRTHPLACE (State or foreign country)
Hungry | | 12. CITIZEN OF WHAT COUNTRY?
Hungary | |
| 13. FATHER'S NAME
Carl Helmbold | | | | 14. MOTHER'S MAIDEN NAME
Helene Albach | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
212-48-0044 | | 17. INFORMANT Rajkay ADDRESS 627 Adershot Road
Alice Rajkay | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)
Metastatic adenocarcinoma, 2 1/2 yrs.
probably pancreatic | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) | | | | 21E. INJURY OCCURRED
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4-3-64 to 1-28-67
that (I) (we) last saw the deceased alive on 1-28-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE
<i>George C. Roveti</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED
2-1-67 | |
| 23C. PHYSICIAN'S NAME (Type)
George C. Roveti | | | | 23D. ADDRESS
M.D. 100 N. Broadway, Balto. 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 24B. DATE
Feb. 2, 1967 | | 24C. NAME OF CEMETERY or CREMATORY
New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT.
FEB 9 1967 | | 25B. NAME OF REGISTRAR
<i>Charles Judge</i> | | 25C. FUNERAL DIRECTOR ADDRESS
G. Truman Schwab 3512 Frederick Ave. Balto. Md. | | | |

VR A15 (4)
25M 1/67

01332



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01896

CERTIFICATE OF DEATH

01892

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
690 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
1639 NORTH BENTALOU STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First GEORGE Middle HENRY Last MILES | | 4. DATE OF DEATH
Month FEBRUARY Day 14 Year 19 67 | | 5. SEX
MALE | | 6. COLOR OR RACE
NEGRO | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DEC. 25, 1896 | | 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months 14 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CHAUFFEUR | | 10b. KIND OF BUSINESS OR INDUSTRY
PRIVATE FAMILY | | 11. BIRTHPLACE (County & State, or foreign country)
DEALS ISLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
GEORGE MILES | | | | 14. MOTHER'S MAIDEN NAME
ELLA WALLACE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
216 01 88 71 | | 17. INFORMANT
CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
MALNUTRITION | | | | | | INTERVAL BETWEEN ONSET AND DEATH
RECENT
MONTHS | |
| | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 2/24/65 , 19 67 , 2/14/67 , 19 67 , that (X) (we) last saw the deceased alive on 2/14/67 , 19 67 , and that death occurred at 5:40A M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
George Dudas M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2/15/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-17-67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
MORTEN & DYETT FUNERAL HOME
1701 Laurens St. Baltimore, Md. | | 25a. REC'D BY REGISTRAR
23 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01836

01836

TO

FROM

PRIVATE PROPERTY

EXHIBIT NO. 1

EXHIBIT NO. 2

EXHIBIT NO. 3

EXHIBIT NO. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

01897

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01893

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | c. LENGTH OF STAY IN 1b
<u>6 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County Gen. Hosp</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Helen</u> Middle <u>L.</u> Last <u>Miller</u> | | 4. DATE OF DEATH
Month <u>2</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>2/9/1880</u> |
| 9. AGE (In years last birthday) yrs.
<u>87</u> | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOME-MAKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Lanahan, CHARLES M.</u> | | 14. MOTHER'S MAIDEN NAME
<u>Snowden, ANNA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-56-8078</u> | |
| 17. INFORMANT
<u>(Chart) W. MILES CARY, JR.</u> | | Address
<u>FALLS ROAD, LUTHERVILLE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>
<u>493X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 WEEK</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/5/67</u> , 19 <u> </u> , to <u>2/10/67</u> , 19 <u> </u> , that (I) <u>we</u> last saw the deceased alive on <u>2/10/67</u> , 19 <u> </u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. Rafael Perez-Mera</u> M.D. | | 22b. DATE SIGNED
<u>2/10/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>DR. RAFAEL PEREZ-MERA</u> | | 22d. ADDRESS
<u>BALTO. COUNTY GENERAL HOSP.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | 23b. DATE THEREOF
<u>2/11/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Greenmount</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co.</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>FEB 14 1967</u> | |

1905 York Rd.
Balto. 12, Md.

618310

OFFICE OF THE SECRETARY OF DEFENSE

618310

| | | | |
|---------------------------------------|--|-------------------------------|--|
| 1. NAME OF THE PERSON OR ORGANIZATION | | 2. ADDRESS | |
| 3. CITY | | 4. STATE | |
| 5. ZIP CODE | | 6. PHONE NUMBER | |
| 7. TITLE | | 8. POSITION | |
| 9. ORGANIZATION | | 10. DATE | |
| 11. SIGNATURE | | 12. PRINTED NAME | |
| 13. ADDRESS | | 14. CITY | |
| 15. STATE | | 16. ZIP CODE | |
| 17. PHONE NUMBER | | 18. FAX NUMBER | |
| 19. E-MAIL ADDRESS | | 20. OTHER CONTACT INFORMATION | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01898

CERTIFICATE OF DEATH

01894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Md. b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
130 Tenbury Rd. | | d. STREET ADDRESS
130 Tenbury Road | |
| 3. NAME OF DECEASED
(Type or print)
Harry J. Mohr | | 4. DATE OF DEATH
Month Day Year
Feb. 17, 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 10, 1885 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner of Meat Store | | 10b. KIND OF BUSINESS OR INDUSTRY
Meat | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Mohr | | 14. MOTHER'S MAIDEN NAME
Margaret Lehmuth | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-44-5627 | |
| 17. INFORMANT
Mabel R. Mohr, Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GENERALIZED METASTATIC CANCER
1992 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF SIGMOID AND BLADDER
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
ASCVD WITH CONGESTIVE FAILURE | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from OCT 20, 1966 to FEB 17, 1967 , that (I) (we) last saw the deceased alive on FEB 14, 1967 , and that death occurred at 12:35 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
T. C. Siwinski | | 22b. DATE SIGNED
2/18/67 | |
| 22c. PHYSICIAN'S NAME (Type)
T. C. SIWINSKI | | 22d. ADDRESS
206 W. PENNA. AVE. TOWSON, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb. 20, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Md. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR
FEB 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Judge | | | |

01810

4210

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01899

CERTIFICATE OF DEATH

01895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
83.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
4541 McKenzie Avenue | |
| 3. NAME OF DECEASED (Type or print)
First John Middle Howard Last Moore | | 4. DATE OF DEATH
Month Feb. Day 1 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-15-99 |
| 9. AGE (In years last birthday) yrs.
67 | | 10. IF UNDER 1 YEAR
Months 67 Days 67 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (County & State, or foreign country)
Tennessee | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Moore | | 14. MOTHER'S MAIDEN NAME
Selma Sexton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
227-18-5539 | |
| 17. INFORMANT
Mrs. Pauline Burkholder; Fairfax, Virginia | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia extensive, right lung
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Old myocardial infarctions. | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that MO (this hospital) attended the deceased from Jan. 3 rd, 1967 , to Feb. 1 st, 1967 , that MO (we) last saw the deceased alive on Feb. 1 st 19 67 , and that death occurred at 3:20 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
M.S. Cockburn, M.D. | | 22b. DATE SIGNED
Feb. 1 st 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
M.S. Cockburn, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moore Family Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Del Rio, Tenn. | |
| 24. FUNERAL DIRECTOR
By Charles Judge Mgr. Fairfax, Virginia | | 25a. REC'D BY REGISTRAR
DATE FEB 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

01893

REPUBLIC OF DENMARK

01893

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01900 Item#2 a,b,c & d Film #G307 4/17/67 pc | | | | 01897 | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House-in-the-Pines - Catonsville | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY W.Va. Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ///Catonsville/// Shinnston
d. STREET ADDRESS Route#42
///17 Fusting Ave. 28
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Murlan | | | | Last Moran | | 4. DATE OF DEATH February 28, 1967 | | Month February | | Day 28 Year 1967 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 7/20/1900 | | 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Elijah Moran | | | | 14. MOTHER'S MAIDEN NAME Mollie Harbert | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes World War I | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT House in the Pines - Catonsville Records
Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac arrest
DUE TO (b) Chronic myocarditis
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 min.
10 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-23, 1966 to 2-28, 1967 that (I) (we) last saw the deceased alive on 2-27, 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Wilmer K. Gallager Sr. M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 3-2-67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallager Sr. | | | | 22d. ADDRESS 6209 Frederick Ave. Baltimore 28 Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 3/6/1967 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fisher & Sons | | | | ADDRESS Baltimore, Md. | | 25a. REC'D BY REGISTRAR DATE MAR 3 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01901

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01896

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>MD.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | | | | c. LENGTH OF STAY IN 1b
<u>21-4</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>ST. JOSEPH HOSPITAL</u> | | | | d. STREET ADDRESS
<u>3604 WHITE AVE</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>Guy</u> Last <u>MORGRET</u> | | | | 4. DATE OF DEATH
Month <u>FEB</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>2-24-13</u> | |
| 9. AGE (In years last birthday)
<u>53</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Clarence Morgret</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mamie ?</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)
<u>Yes W W 2</u> | | | | 16. SOCIAL SECURITY NO.
<u>172-18-0241</u> | | 17. INFORMANT
<u>Mr. James G. Morgret Jr. Johnstown, Pa.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u> | | | | 22. DATE SIGNED
DEPUTY MEDICAL EXAMINER <u>BALTIMORE</u>
Address (Street, city, town, or county) <u>2-3-67</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/8/67.</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 8 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

11330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01902

CERTIFICATE OF DEATH

01898

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Balto. Co.
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) Lutherville
c. LENGTH OF STAY IN 1b 5 Mon.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 119 Croftley Rd. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead
d. STREET ADDRESS R.D. 2
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Andrew (Netraj) Netro | | 4. DATE OF DEATH
Month Feb. Day 9, Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 23, 1883 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR
Months 8 Oays 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Chechoslovakia | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Netro | | 14. MOTHER'S MAIDEN NAME Judita Hamlik | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-34-6145 | |
| 17. INFORMANT Mrs. Julia Netro | | Address Hampstead, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO coronary insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ?
(c) ? | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 25, 1967 to Feb 9, 1967 , that (I) (we) last saw the deceased alive on Jan 25, 1967 and that death occurred at 8:15 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE George T. Gilmore M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) Dr. George T. Gilmore, M. D. | | 22b. DATE SIGNED Feb 10, 1967 | |
| 22d. ADDRESS 1717 York Road, Lutherville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/11/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hampstead | | 23d. LOCATION (City or Town) (County) (State) Hampstead, Carroll Md. | |
| 24. FUNERAL DIRECTOR Tipton - Eline Funeral Home | | ADDRESS Hampstead, Md. | |
| 25a. REC'D BY REGISTRAR FEB 14 1967 | | 25b. REGISTRAR'S SIGNATURE Judge | |

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HEAD OF THE HOUSE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01903

CERTIFICATE OF DEATH

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| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY in lb <u>10 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21222</u>
d. STREET ADDRESS <u>7016 Brentwood Cir</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Thomas</u> Middle <u>Anthony</u> Last <u>Nichols</u> | | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>8</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1-17-1883</u> | | 9. AGE (In years last birthday) <u>84</u> yrs.
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Athens, Greece</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>One Honey Nicholas</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Florzenes</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>172-03-4400</u> | | 17. INFORMANT Address <u>SEE # 2 ABOVE</u>
<u>MRS. EDW. A. O'BARA</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Metastases</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Stomach</u> DUE TO _____
(c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour _____ a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 29th</u> 19 <u>67</u> , to <u>Feb. 8th</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 8th</u> 19 <u>67</u> , and that death occurred at <u>9:40pm</u> , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Dr. Isabelle Mae Gregor</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-8-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>1. MAE GREGOR</u> | | | | 22d. ADDRESS
<u>Greater Baltimore Medical Center</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>2/13/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GRAND VIEW</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>JOHNS TOWN, PENN</u> | | | |
| 24. FUNERAL DIRECTOR
<u>W. Brooks Bradley, Dundalk, Md</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 10 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01883

CERTIFICATE OF DEATH

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Curran's
West

for 2000 25 25 25

for 2000 25 25 25

Mr. Wallace
1 MacGregor

10 25 25

John Wallace

John Wallace

John Wallace

John Wallace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01904 | | | | | | 01900 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE <u>Ind.</u> b. COUNTY <u>Balto</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | c. LENGTH OF STAY IN Id
<u>4 months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Dulaney Towson Nursing Home</u> | | | | | | d. STREET ADDRESS
<u>8034 Kavanagh Rd</u> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Annie</u> Middle <u></u> Last <u>O'Harc</u> | | | | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>16</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Apr. 20, 1888</u> | | 9. AGE (In years last birthday)
<u>78</u> yrs. | | IF UNDER 1 YEAR
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u></u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Ireland</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>CARL Miller</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>102 07 3768</u> | | 17. INFORMANT
<u>Nursing Home Record Towson</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u>
DUE TO (c) <u></u>
INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebrovascular insufficiency due to Arteriosclerosis</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-17-1966</u> , to <u>2-16, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-15-1967</u> , and that death occurred at <u>2:15</u> AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>James J. McPhillips</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2-16-67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JAMES J. McPHILLIPS</u> | | | | | | 22d. ADDRESS
<u>4617 MANORDENE RD BALTIMORE MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>Feb 20, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Charles Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Long Island, New York</u> | | | |
| 24. FUNERAL DIRECTOR
<u>W. Cook-Brooks Towson - 1050 York Rd Towson, Md</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>FEB 20 1967</u> | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>James J. McPhillips</u> | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 01905 | | | | | 01901 | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY
BALTIMORE | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | a. STATE
MARYLAND | | | b. COUNTY
BALTIMORE | | |
| c. LENGTH OF STAY IN 1b
11 DAYS | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | | d. STREET ADDRESS
8132 MIDHAVEN ROAD | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | 5. SEX | | | | | |
| First Middle Last
JACK D. O'NEAL | | | Month Day Year
FEBRUARY 7 1967 | | 6. COLOR OR RACE
WHITE | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
SEPTEMBER 19, 1898 | | 9. AGE (In years lost birthday) yrs.
68 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MAINTENANCE | | | 10b. KIND OF BUSINESS OR INDUSTRY
MOTOR LODGE | | 11. BIRTHPLACE (County & State, or foreign country)
PORT REPUBLIC, VA. | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
CHARLES O'NEAL | | | | | 14. MOTHER'S MAIDEN NAME
EMMA VANLEAR | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | | 16. SOCIAL SECURITY NO.
204 001 87 50 | | 17. INFORMANT
VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, UNDETERMINED ORGANISM
202.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) —
DUE TO (c) LYMPHOMA | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 DAYS | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
CEREBRAL ARTERIOSCLEROSIS; CHRONIC PYELONEPHRITIS, STREPT. FECALIS | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JAN. 27 , 19 67 , to FEB. 7 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEB. 7 , 19 67 , and that death occurred at 925 PM , from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
<i>Neilson Neilson M.D.</i> | | | 22b. DATE SIGNED
2/8/67 | | | 22c. PHYSICIAN'S NAME (Type)
NEILSON NEILSON, M. D. | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
2/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
<i>Joseph N. Zannino</i> | | | 25a. REC'D BY REGISTRAR
1967 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | 25c. DATE
1967 | |
| 25d. ADDRESS
257 S. Conkling St. Baltimore, Md. | | | | | | | | | | |

01302

CONTINUATION OF REPORT

REPORT NO. 01302 DATE 10/10/54

REPORT NO. 01302 DATE 10/10/54

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|------------------------------|---|---|---|---|---|---|--|
| 01906 | | | | | 01902 | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Dulaney Towson Nursing Home | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
Jesse | | | First Middle Last
Loeffler Palmer | | | 4. DATE OF DEATH
Month Day Year
February 7 19 67 | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/29/1877 | | 9. AGE (In years last birthday)
89 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Pittsburgh, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Loeffler | | | | | 14. MOTHER'S MAIDEN NAME
Rachel Owens | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | 16. SOCIAL SECURITY NO.
216-09-1437 | | 17. INFIRMARY
Mrs. Anne L. Sinclair-Smith, Tenn. | | | Address
Nashville, | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1958 to Feb 7, 1967 , that (I) (we) last saw the deceased alive on Feb 7, 1967 , and that death occurred at 8:20 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
William G. Helfrich | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-8-67 | | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. William G. Helfrich | | | | | 22d. ADDRESS
5006 Roland Ave. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
2/9/1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge | | 23d. LOCATION (City, town or county) (State)
Pikesville, Balto. Co. Md. | | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

01200

01200

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11/15/1977

Michael O'Brien

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01907

CERTIFICATE OF DEATH

01903

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
59 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
3038 BRIGHTON STREET | |
| 3. NAME OF DECEASED (Type or print)
First LOUIS Middle DAVIDSON Last PARKER | | 4. DATE OF DEATH
Month FEBRUARY Day 24 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
MARCH 22, 1906 |
| 9. AGE (In years last birthday) yrs.
60 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | |
| 11. BIRTHPLACE (County & State, or foreign country)
BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
DONALD PARKER | | 14. MOTHER'S MAIDEN NAME
ALETHEA DAVIS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
718 03 34 85 | |
| 17. INFORMANT
CLINICAL RECORDS FORT HOWARD, MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE
161X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LARYNX DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
MINUTES
8 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 27 , 19 66 , to FEB. 24 , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on FEB. 24 , 19 67 , and that death occurred at 500PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Jose A. Raquel Jr.</i> | | 22b. DATE SIGNED
2-24-67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOSE A. RAQUEL JR., M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/28/67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
NUTTER FUNERAL HOME | | 25a. REC'D BY REGISTRAR
FEB 27 1967 | |
| 3035 W. NORTH AVENUE, BALTIMORE, MARYLAND | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

01908

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01904

| | | | | | |
|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | c. LENGTH OF STAY IN 1b
3 yrs. | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Rosewood State Hospital | | | d. STREET ADDRESS
341 North Jonathan St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle DEWITT Last PARSON | | | 4. DATE OF DEATH
Month 2 Day 16 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-15-56 | 9. AGE (In years last birthday)
10 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Harford County, Md. | |
| 13. FATHER'S NAME
Tom Parson | | | 14. MOTHER'S MAIDEN NAME
Yvonne Elizabeth Medley | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Post hepatic liver cirrhosis | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Rudiger Breiteneker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
2/17/67 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Feb 21 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Md. | | |
| 24. FUNERAL DIRECTOR
John R Watson Jr. Hagerstown Md. | | ADDRESS | | 25d. REC'D BY REGISTRAR
DATE FEB 20 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01905

CERTIFICATE OF DEATH

01905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|----------------------------------|---|--|--|---------------------------|---|------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
29 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson (Ruxton Towers) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | | | d. STREET ADDRESS
8415 Bellona Lane | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HARVEY Middle M Last PATTERSON | | | | 4. DATE OF DEATH
Month FEB. Day 15 Year 1967 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 14, 1914 | 9. AGE (In years last birthday)
52 yrs. | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Reathy Mack Patterson | | | | 14. MOTHER'S MAIDEN NAME
Lula Mae Bryant | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
2/ | | 17. INFORMANT
Wayne D. Albrecht, Baltimore, Maryland 21229 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221 ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1-16 , 19 67 , to 2-15 , 19 67 , that (I) (we) last saw the deceased alive on 2-15 , 19 67 , and that death occurred at 11:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Juan L. Roque | | | | 22b. DATE SIGNED
2-15-67 | | 22c. PHYSICIAN'S NAME (Type)
JUAN L. ROQUE | |
| 22d. ADDRESS
6BMC. Towson, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb. 18, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cockeysville, Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR
FEB 20 1967 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | 01906 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Id.</u> b. COUNTY <u>Balto.</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Garrison</u> | | | | c. LENGTH OF STAY IN 1b
<u>20 da</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balto.</u> 30-4 | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Foxleigh Nursing Home.</u> | | | | | | d. STREET ADDRESS
<u>3834 Ball Mall Rd</u> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>HAROLD</u> N. Middle <u>N.</u> Last <u>PEARLSTEIN</u> | | | | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>14</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>White</u>
<u>m</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5/23/1890</u> 76 yrs. | | 9. AGE (In years last birthday)
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retail Clothing</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Poland</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME <u>Salesman</u>
<u>Moishe Pearlstein</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>110-05-8046</u> | | 17. INFORMANT
<u>Harold Pearlstein</u> Address | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>melanocarcinoma disseminated</u>
<u>1969</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH <u>over 2 months</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>75</u> , to <u>7/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>67</u> , and that death occurred at <u>4:15</u> A.M., from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Milton B. Kirsh</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>7/14/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Milton B. Kirsh, M.D.</u> | | | | | | 22d. ADDRESS
<u>4000 W. Northern Parkway - 21215</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/15/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Anshe Emunah-Aitz Chaim</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Sol Levinson & Bros. Inc.,</u> | | | | | | 25a. REC'D BY REGISTRAR
<u>FEB 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | | c. LENGTH OF STAY IN 1b
<u>1 year</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Forest Haven Nursing Home</u> | | | | d. STREET ADDRESS
<u>1823 Gough Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>First Middle Last</u>
<u>GUISEPPI A. PELUSO</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10/1/1876</u> | | 9. AGE (In years last birthday)
<u>90</u> yrs. | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Manufacturer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Macaroni</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Italy</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Italy</u> ✓ | |
| 13. FATHER'S NAME
<u>Guy Peluso</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>—</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT
<u>Patsy Peluso 327 S. Ann Street (Son)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u>
DUE TO <u>422.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic changes - coronary</u>
DUE TO <u>—</u>
(c) <u>DISEASES</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>—</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>—</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>—</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>—</u> | | 20f. (City or town) (County) (State)
<u>—</u> | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>66</u> , to <u>2/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>67</u> , and that death occurred at <u>6:12 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>John H. Shaw M.D.</u> | | | | 22b. DATE SIGNED
<u>2/6/67</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John H. Shaw M.D.</u> | | | | 22d. ADDRESS
<u>5500 Edmonson Ave Baltimore, Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Stanislaus Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Charles E. Johnson</u> | | | | 25a. REC'D BY REGISTRAR
<u>—</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 24. ADDRESS
<u>Forest Haven Blvd.</u> | | | | DATE <u>FEB 14 1967</u> | | | |

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UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

1. NAME (Last, First, Middle Initial)
2. GRADE
3. TITLE
4. DEPARTMENT
5. ADDRESS
6. CITY
7. STATE
8. ZIP CODE
9. PHONE NUMBER
10. FAX NUMBER
11. E-MAIL ADDRESS
12. DATE
13. SIGNATURE
14. PRINTED NAME
15. POSITION
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143. E-MAIL ADDRESS
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175. STATE
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194. PRINTED NAME
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196. ORGANIZATION
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199. STATE
200. ZIP CODE
201. PHONE NUMBER
202. FAX NUMBER
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243. POSITION
244. ORGANIZATION
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247. STATE
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290. PRINTED NAME
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1385. ADDRESS
1386. CITY
1387. STATE
1388. ZIP CODE
1389. PHONE NUMBER
1390. FAX NUMBER
1391. E-MAIL ADDRESS
1392. DATE
1393. SIGNATURE
1394. PRINTED NAME
1395. POSITION
1396. ORGANIZATION
1397. ADDRESS
1398. CITY
1399. STATE
1400. ZIP CODE
1401. PHONE NUMBER
1402. FAX NUMBER
1403. E-MAIL ADDRESS
1404. DATE
1405. SIGNATURE
1406. PRINTED NAME
1407. POSITION
1408. ORGANIZATION
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1425. PHONE NUMBER
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1430. PRINTED NAME
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1451. E-MAIL ADDRESS
1452. DATE
1453. SIGNATURE
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1461. PHONE NUMBER
1462. FAX NUMBER
1463. E-MAIL ADDRESS
1464. DATE
1465. SIGNATURE
1466. PRINTED NAME
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1476. DATE
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1488. DATE
1489. SIGNATURE
1490. PRINTED NAME
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1492. ORGANIZATION
1493. ADDRESS
1494. CITY
1495. STATE
1496. ZIP CODE
1497. PHONE NUMBER
1498. FAX NUMBER
1499. E-MAIL ADDRESS
1500. DATE
1501. SIGNATURE
1502. PRINTED NAME
1503. POSITION
1504. ORGANIZATION
1505. ADDRESS
1506. CITY
1507. STATE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01912

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01908

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk
c. LENGTH OF STAY IN 1b 10 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8172 Kavanagh Road (Sidewalk) | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk
d. STREET ADDRESS 8134 Kavanagh Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARCUS Middle Sarafin Last PENA | | 4. DATE OF DEATH
Month February Day 16 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 22-1922 |
| 9. AGE (In years lost birthday) 44 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jockey | | 10b. KIND OF BUSINESS OR INDUSTRY Race Tracks | |
| 11. BIRTHPLACE (State or foreign country) Havana, Cuba | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sarafin Pena | | 14. MOTHER'S MAIDEN NAME Angela Zaballa | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 508-20-4818 | |
| 17. INFORMANT Wife, Eileen, Pena, #2, a, b, c, d, . | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Rudiger Breiteneker, MD
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 22. DATE SIGNED 2/17/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Feb-22-1967 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | 23d. LOCATION (City or Town) (County) (State) Miami, Dade County, Florida |
| 24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222 | | ADDRESS | |
| 25a. REC'D BY REGISTRAR FEB 20 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01913

01909

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN lb | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
427 Langley Road | | d. STREET ADDRESS
427 Langley Road, Edgewater Apt.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Chalmer Middle Dean Last PHIPPS | | 4. DATE OF DEATH
Month February Day 12 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 4, 1917 |
| 9. AGE (In years lost birthday) yrs.
49 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | |
| 13. FATHER'S NAME
Charlie W Phipps | | 14. MOTHER'S MAIDEN NAME
Margaret Cox | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
244-14-3448 | |
| 17. INFORMANT
Howard Phipps | | Address
same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5810 Lobar pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Fatty metamorphosis of liver
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Partial |
| 20f. (City or town) _____ (County) _____ (State) _____ | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 22. ACTUAL SIGNATURE
Russell S. Fisher, M.D.
EXAMINER'S NAME (Type) | | 22. DATE SIGNED
February 20, 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE THEREOF
2/22/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Valley | | 23d. LOCATION (City or Town) _____ (County) _____ (State) N.C. | |
| 24. FUNERAL DIRECTOR
Badger Funeral Home | | 25a. REC'D BY REGISTRAR
FEB 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
William J. Jones | | | |

MEDICAL CERTIFICATION

010010

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01914

CERTIFICATE OF DEATH

01910

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
1 DAY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle POINDEXTER Last POINDEXTER | | 4. DATE OF DEATH
Month FEBRUARY Day 22 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 3, 1900 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 9b. AGE (In years last birthday)
66 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY
MONROE COUNTY, ALABAMA | |
| 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACK POINDEXTER | | 14. MOTHER'S MAIDEN NAME
MINERVA MAGTIE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWII | | 16. SOCIAL SECURITY NO.
233 14 42 81 | |
| 17. INFORMANT
VA HOSPITAL | | 18. CLINICAL RECORDS
FORT HOWARD, MARYLAND | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) PASSIVE CONGESTION OF THE HEART
(c) ARTERIOSCLEROTIC HEART DISEASE | | INTERVAL BETWEEN ONSET AND DEATH
DAYS
MONTHS
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from FEB. 21 , 19 67 , to FEB. 22 , 19 67 , that (1) (we) last saw the deceased alive on FEB 22 , 19 67 , and that death occurred at 205PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Peter V. Juvan</i> | | 22b. DATE SIGNED
2/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
PETER V. JUVAN, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-27-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR
<i>Turnell S. Oden</i> | | 25a. REC'D BY REGISTRAR
ODEN FUNERAL HOME | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | DATE
MAR 3, 1967 | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01915

01911

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>615 Chestnut Ave. Towson</u> | | c. LENGTH OF STAY IN 1b
<u>Years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Good Women & Mens Home</u> | | d. STREET ADDRESS
<u>1502 Hollins ST</u> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>William Causey Polk</u> | | 4. DATE OF DEATH
Month Day Year
<u>February 17 19 67</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 27 1878</u> |
| 9. AGE (In years last birthday)
<u>88</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Elv. Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Sikesville Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Truett Polk</u> | | 14. MOTHER'S MAIDEN NAME
<u>Louise Dorsey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-07-4335</u> | |
| 17. INFORMANT
<u>E. McElfresh</u> | | Address
<u>615 Chestnut Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis Heart Disease</u>
DUE TO (c) <u>Bronchopneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 20</u> , 19 <u>58</u> , to <u>Feb. 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17</u> , 19 <u>67</u> , and that death occurred at <u>11:35 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Newland Edward Day</u> | | 22b. DATE SIGNED
<u>February 18, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Newland Edward Day</u> | | 22d. ADDRESS
<u>4-E-33rd St Baltimore Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 21, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Oliver</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson, Towson, Maryland 21204</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 20 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1916

RECEIVED

1916

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Acute myocardial infarct
Anterior wall of heart
Bicuspid valvular

Myocardial infarct

4-8-30 (1) Bellamy, William

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01916 | | | | | 01912 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY <u>Balto.</u> MARYLAND | | | | | a. STATE <u>md.</u> b. COUNTY <u>4</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Balto. County General Hospital</u> | | | | | d. STREET ADDRESS <u>5306 Belleville Rd.</u> | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | |
| First <u>Rebecca</u> Middle <u>N.M.I.</u> Last <u>POLUN</u> | | | | | Day <u>2</u> Month <u>15</u> Year <u>1967</u> | | | | |
| 5. SEX <u>F</u> | | | | | 6. COLOR OR RACE <u>W</u> | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH <u>XXXXXXXXXXXX</u> | | | | |
| 9. AGE (In years last birthday) <u>30</u> yrs. | | | | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>AT Home</u> | | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Russia</u> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>?</u> | | | | |
| 13. FATHER'S NAME
<u>Hillel Eisenberg</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Brina ?</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | | | 16. SOCIAL SECURITY NO.
<u>No</u> | | | | |
| 17. INFIRMANT
<u>Mrs. Mindel Rudman, 5306 Belleville Ave.</u> | | | | | Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>possible ful. embolism</u> | | | | | | | | | |
| 4201 (b) <u>Recent suppurative infection</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Congestive Heart Failure</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Generalized arteriosclerosis</u> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/21/67</u> , 19 <u>67</u> , to <u>2/15/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/15/67</u> , 19 <u>67</u> , and that death occurred at <u>8:40</u> AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Dr. Joya</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>2-15-67</u> | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. JOYA</u> 22d. ADDRESS <u>B. E. G. H.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/16/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mens</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> 25a. REC'D BY REGISTRAR <u>FEB 20 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01917

01913

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>14 Overbrook Rd.</u> | | d. STREET ADDRESS
<u>14 Overbrook Rd.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Anna</u> Middle <u>W.</u> Last <u>Poske</u> | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>4</u> Ooy <u>19</u> Year <u>67</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-20-90</u> |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Late - Henry Knapp</u> | | 14. MOTHER'S MAIDEN NAME
<u>Late - Mary Klein</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. Henry Frei</u> Address
<u>Box 41-Fork Road, Baldwin, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Cardiovascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>2/4</u> 19 <u>67</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>James N. Frederick</u> | | 22b. DATE SIGNED
<u>2/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>James Frederick</u> | | 22d. ADDRESS
<u>1311 Francis Ave.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2-8-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Witzke F.D.-4101 Edmondson Ave.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 8 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01310

01310

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

IN THE COUNTY OF

STATE OF

1900

1900

DECEASED

DECEASED

WIFE OF

WIFE OF

MR. HENRY

MR. HENRY

DECEASED

DECEASED

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01914

FOR STATE
HEALTH DEPT.

01918

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTO MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD b. COUNTY BALTO | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ESSEX | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4 C WESTWAY SOUTH | | | | d. STREET ADDRESS
4 C WESTWAY SOUTH | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
JOHN C. PULLIAM | | | | 4. DATE OF DEATH
Month Day Year
FEB 2 19 67 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 27 1913 | | 9. AGE (In years last birthday)
53 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
MARTIN CO | | 11. BIRTHPLACE (State or foreign country)
VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
WALTER S. PULLIAM | | | | 14. MOTHER'S MAIDEN NAME
MARY GORDON | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
UNK | | 16. SOCIAL SECURITY NO.
223-16-7557 | | 17. INFORMANT
MARIE PULLIAM | | Address
ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V-DISEASE
DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
None | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
M.B. Davis | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
2/3/67 | |
| EXAMINER'S NAME (Type)
M.B. Davis | | M.D.
MD-6800 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, county, state)
St. Charles Judge | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
GARDENS OF FAITH | | 23d. LOCATION (City or Town) (County) (State)
BALTO MD. | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | | ADDRESS
300 MACE | | 25a. REC'D BY REGISTRAR
DATE FEB 7 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01919

01915

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
4yr9mth14dys | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis, Maryland | | d. STREET ADDRESS
Box 122- R.F.D. #3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle = Last Purcell | | 4. DATE OF DEATH
Month February Day 2 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
? 1877 |
| 9. AGE (In years birth day) 89 yrs. | | IF UNDER 1 YEAR
Months 10 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
construction worker | | 10b. KIND OF BUSINESS OR INDUSTRY
Ireland | |
| 11. BIRTHPLACE (County & State, or foreign country)
Ireland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Simon Purcell | | 14. MOTHER'S MAIDEN NAME
Johanna Mascall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
186-03-8943 | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4221
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Arteriosclerosis, generalized
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that the (this hospital) attended the deceased from April 18 19 62 to Feb. 2 , 19 67 , that the (we) last saw the deceased alive on Feb. 2 19 67 , and that death occurred at 8:15 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stella Wachslar
M.D. | | 22b. DATE SIGNED
2-2-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/4/1967 | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARY'S CATHEDRAL CEM. | 23d. LOCATION (City or Town) (County) (State)
TRENTON N.J. |
| 24. FUNERAL DIRECTOR
John M. Taylor Sons Annapolis Md. | | 25. REC'D BY REGISTRAR
DATE FEB 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK
c. LENGTH OF STAY IN 1b 27 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1900 WASHINGTON ROAD | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 21222
d. STREET ADDRESS 1900 WASHINGTON ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARIE DEITZ
First Middle Last
4. DATE OF DEATH 2/14/1967
Month Day Year | | 5. SEX FEMALE
6. COLOR OR RACE CAUCASIAN
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11/29/1908
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE DEITZ
14. MOTHER'S MAIDEN NAME EMMA J. AILSHIRE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE
17. INFORMANT JACK RABER (AS IN 2 ABOVE)
Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) STRANGULATION by HANGING -
974X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Heavy fall from attic rafters
20c. TIME OF INJURY Month, Day, Year 4:15 a.m. 2-14-67
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Dundalk Balto Md. | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22. DATE SIGNED 2/16/67
Address (Street, city, town or county) DUNDALK BAL. CO. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 2/17/67
23c. NAME OF CEMETERY OR CREMATORY OAKLAWN
23d. LOCATION (City, town or county) (State) BALTO. CO. MARYLAND | | 24. FUNERAL DIRECTOR W. Brooks Bradley
ADDRESS DUNDALK, MD.
25a. REC'D BY REGISTRAR FEB 17 1967
25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01921

CERTIFICATE OF DEATH

01917

| | | | | | | | |
|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | | c. LENGTH OF STAY IN 1b _____ | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore - 21224 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
702 South Highland Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Katherine Katie Ramsauer | | | | 4. DATE OF DEATH February 4, 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
June 2, 1905 | | 9. AGE (In years last birthday)
61 yrs. | 11. BIRTHPLACE (County & State, or foreign country)
Germany | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Anton Wild | | | | 14. MOTHER'S MAIDEN NAME
Bertha Weisinger | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT Carl F. Holtz Address 8E Hillcrest Circle Rochester, N.Y. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral artery thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis, generalized
DUE TO
(c) Portal cirrhosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (if) (this hospital) attended the deceased from January 22, 1967 , to February 4, 1967 , that (he) (we) last saw the deceased alive on February 4, 1967 , and that death occurred at 8:05 A.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ramon P. Lopez | | | | 22b. DATE SIGNED
February 4, 1967 | | 22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M. D. | |
| 22d. ADDRESS
7620 York Road, Towson 4, Md. | | | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-7-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | 23d. LOCATION (City or Town) (County) (State)
4701 German Hill Rd., Md. | |
| 24. FUNERAL DIRECTOR
Charles S. Giles | | | | 25. REC'D BY REGISTRAR
DATE FEB 7 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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June 8, 1968

Carroll R. Brown and Margaret Brown
Huntington, West Virginia

Union 1976

At Home

Home

2-5-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01922

01918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|-------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN lb
126 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS
71 WINTERS LANE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle WILLIAM Last RANDALL | | | 4. DATE OF DEATH
Month FEBRUARY Day 14 Year 19 67 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/3/07 | 9. AGE (In years last birthday) yts.
59 | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY
DELIVERY TRUCK | | 11. BIRTHPLACE (County & State, or foreign country)
CATONSVILLE, MARYLAND | |
| 13. FATHER'S NAME
LLOYD RANDALL | | | 14. MOTHER'S MAIDEN NAME
Minerva STEWART | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
215 12 78 46 | | 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA
DUE TO (b) ARTERIOLEAR NEPHROSCLEROSIS
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH
MONTHS
MONTHS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
HYPERTENSIVE CARDIOVASCULAR DISEASE. DIABETES MELLITUS. | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 2Dc. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 2Dd. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/11/66 , 19__, to 2/14/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/14/67 , 19__, and that death occurred at 9:40A M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>George Dudas</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2/14/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/17/67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR | | ADDRESS
NUTTER FUNERAL HOME | | 25a. REC'D BY REGISTRAR
55B 15 1967 | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |
| 3035 W. North Ave. Baltimore, Md. | | | | | |

01312

CERTIFICATE OF DEATH

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AT WINTER LAKE

THE WINTER LAKE HOSPITAL

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BALTIMORE, MARYLAND, VA HOSPITAL, AT WINTER LAKE, MD.

BALTIMORE, MARYLAND, VA HOSPITAL, AT WINTER LAKE, MD.

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BALTIMORE, MARYLAND, VA HOSPITAL, AT WINTER LAKE, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01923

CERTIFICATE OF DEATH

01919

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
3mth14dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Otis Middle Reagan Last Reagan | | 4. DATE OF DEATH
Month February Day 2 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 18, 1888 |
| 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR
Months 07 Days 2 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Archibald | | 14. MOTHER'S MAIDEN NAME
Georganna Blades | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
214-18-2974 | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROTIC CARDIOVASCULAR HEART DTS. 20 yrs.
DUE TO
(c) ARTERIOSCLEROSIS, GENERALIZED 20 yrs. | | INTERVAL BETWEEN ONSET AND DEATH
ACUTE | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary emphysema and pulmonary fibrosis | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. <input type="checkbox"/> p.m. <input type="checkbox"/> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from Oct. 18, 1966 to Feb. 2, 1967 that (1) (we) last saw the deceased alive on Feb. 2, 1967 , and that death occurred at 16:50 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | 22b. DATE SIGNED
2-2-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/10/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
ST. Johns | | 23d. LOCATION (City or Town) (County) (State)
Howard Co. Md. | |
| 24. FUNERAL DIRECTOR
E.S. Mac Nabbs | | 25a. REC'D BY REGISTRAR
BALTO 21228 MH | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
FEB 14 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01214

RECEIVED OF DEATH

01214



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>019224</p> <p>01920</p> </div> </div> | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY Baltimore County MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson</p> <p>c. LENGTH OF STAY IN 1b 120 days</p> | | | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE Maryland b. COUNTY City</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21217</p> <p>d. STREET ADDRESS 1143 N. Mount St.</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | | |
| <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital</p> | | | | | | | | | | | |
| <p>3. NAME OF DECEASED (Type or print) Viola</p> | | <p>First Middle Last Redmond</p> | | <p>4. DATE OF DEATH Feb 1 1967</p> | | <p>Month Day Year</p> | | | | | |
| <p>5. SEX F</p> | | <p>6. COLOR OR RACE C</p> | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH 6-12-91</p> | | <p>9. AGE (in years last birthday) 75 yrs.</p> | | <p>IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p> | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) huf.</p> | | | | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (County & State, or foreign country) Virginia</p> | | <p>12. CITIZEN OF WHAT COUNTRY? USA</p> | | | |
| <p>13. FATHER'S NAME John Watty</p> | | | | | | <p>14. MOTHER'S MAIDEN NAME Mary Shelton</p> | | | | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</p> | | | | <p>16. SOCIAL SECURITY NO. 219-30-8374</p> | | <p>17. INFORMANT Address Records, Mt. Wilson State Hospital</p> | | | | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Tuberculous Meningitis</p> <p>002.1 DUE TO (b) _____</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____</p> | | | | | | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH 5mo.</p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>Minimal Pulmonary Tuberculosis</p> | | | | | | | | | | | |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> | | | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> | | | | <p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) (County) (State)</p> | | | |
| <p>21. I certify that (I) (this hospital) attended the deceased from 10-4, 19 66, to 2-1, 19 67, that (I) (we) last saw the deceased alive on 2-1 19 67, and that death occurred at 2:20 PM, from the causes and on the date stated above.</p> | | | | | | | | | | | |
| <p>22a. SIGNATURE Wm. Newcomer</p> | | | | | | <p>22b. DATE SIGNED 2-1-67</p> | | | | | |
| <p>22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent</p> | | | | | | <p>22d. ADDRESS Mount Wilson, Maryland</p> | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p> | | | | <p>23b. DATE THEREOF 2-6-67</p> | | <p>23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pl.</p> | | <p>23d. LOCATION (City, town or county) (State) Arbutus, Md.</p> | | | |
| <p>24. FUNERAL DIRECTOR George A. Klon</p> | | | | | | <p>25a. REC'D BY REGISTRAR FFB 3</p> | | <p>25b. REGISTRAR'S SIGNATURE Charles Judge</p> | | | |

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21/12/19

may 24/10

John Watty
Hwy 4

SM-30-8376 Records, W. Wilson State Hospital

Tapetum album album

OMZ

Primary Pulmonary Tuberculosis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (attach) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

01921

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|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>03-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>601 Edmondson Ave.</u> | | d. STREET ADDRESS
<u>601 Edmondson Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Edward</u> Middle <u>William</u> Last <u>Reichelt</u> | | 4. DATE OF DEATH
Month <u>February</u> Day <u>25</u> Year <u>19 67</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Aug. 23, 1905</u> |
| 9. AGE (In years last birthday)
<u>61</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Furnace tender</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Refining Co.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Arthur Reichelt</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Vetter</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212101827</u> | |
| 17. INFORMANT
<u>Mrs Elsie Reichelt</u> | | Address
<u>same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Squamous cell Carcinoma left neck</u>
<u>1914</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>(Primary unknown)</u>
(c) <u>cerebral extension (Probably lung)</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>14 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>65</u> , to <u>Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>27 Jan.</u> 19 <u>67</u> , and that death occurred at <u>3:41</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Arthur G. Siwinski</u> | | 22b. DATE SIGNED
<u>25 Feb 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Arthur G. Siwinski</u> | | 22d. ADDRESS
<u>836 Park Ave</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>buried</u> | | 23b. DATE THEREOF
<u>2/28/67.</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 27 1967</u> | |
| ADDRESS
<u>Baltimore, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

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01981

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 10, 1901

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

FOR THE YEAR

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PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01926

Item #8 Film #G305 2/20/67 pv

01922

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Reisterstown</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Reisterstown</u> | | | |
| c. LENGTH OF STAY IN Ib
<u>1 year</u> | | | | d. STREET ADDRESS
<u>308 Highmeadow Road</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>308 Highmeadow Road</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>EDGAR A. REILLY, Sr.</u> | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>11</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1889</u>
<u>Nov. 6, 1890</u> | |
| 9. AGE (In years last birthday)
<u>77</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Interior Decorator</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-Employed</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Charles H. Reilly</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Lee Jacobs</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u> </u> | | | | 16. SOCIAL SECURITY NO.
<u>213-10-4258</u> | | | |
| 17. INFORMANT
<u>Mrs. Beulah M. Reilly</u> | | | | Address
<u>308 Highmeadow Rd. Reisterstown, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma - st. eye</u>
DUE TO (b) <u>Metastasis to lung.</u>
DUE TO (c) <u>cachexia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u> | | | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-65</u> to <u>2-11-67</u> that (I) (we) last saw the deceased alive on <u>2-11-67</u> and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>James G. Saffell M.D.</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>James G. Saffell M.D.</u> | | | | 22d. ADDRESS
<u>Reisterstown, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>2/14/67</u> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State)
<u>Woodlawn, Maryland</u> | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>H. J. Eichhardt</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | | |
| ADDRESS
<u>Owings Mills, Md.</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |
| DATE
<u>FEB 14 1967</u> | | | | | | | |

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THE UNIVERSITY OF CHICAGO
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637
U.S.A.

TO: THE DIRECTOR, NATIONAL BUREAU OF STANDARDS
WASHINGTON, D.C. 20540

FROM: DR. J. H. GOLDSTEIN, CHAIRMAN
COMMISSION ON CHEMICAL Nomenclature
NATIONAL ACADEMY OF SCIENCES
WASHINGTON, D.C. 20540

SUBJECT: PROPOSAL FOR THE REVISION OF THE
NOMENCLATURE OF ORGANIC CHEMISTRY

Enclosed for the Bureau are two copies of a report
prepared by the Commission on Chemical Nomenclature
of the National Academy of Sciences. The report
contains a summary of the work of the Commission
and a list of recommendations for the revision of
the nomenclature of organic chemistry.

The Commission was organized in 1964 by the
National Academy of Sciences to study the
nomenclature of organic chemistry and to make
recommendations for its revision. The Commission
has held several public hearings and has received
many suggestions from chemists and other
interested persons. The report contains a
summary of the work of the Commission and a
list of recommendations for the revision of
the nomenclature of organic chemistry.

The Commission believes that the recommendations
contained in the report will result in a
nomenclature that is more logical, more
consistent, and more useful than the present
nomenclature. The Commission believes that the
recommendations should be adopted by the
International Union of Pure and Applied Chemistry
(IUPAC) and by the American Chemical Society
(ACS).

The Commission believes that the recommendations
contained in the report will result in a
nomenclature that is more logical, more
consistent, and more useful than the present
nomenclature. The Commission believes that the
recommendations should be adopted by the
International Union of Pure and Applied Chemistry
(IUPAC) and by the American Chemical Society
(ACS).

Very truly yours,
J. H. Goldstein, Chairman
Commission on Chemical Nomenclature
National Academy of Sciences
Washington, D.C. 20540

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01927

Items 2, 3, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

01923

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|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21228 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa, 6400 Bellona Avenue | | d. STREET ADDRESS 3307 Rollingdale Rd. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth E. Reiter | | 4. DATE OF DEATH Month Day Year 2 10 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/11/1883 |
| 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Nicholas Reiter | | 14. MOTHER'S MAIDEN NAME Mary Louise Kohler | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of urinary tract
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
4 mo. 10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1952 to 3/10 , 19 67 that (I) (we) last saw the deceased alive on 2/6 , 19 67 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert A. Reiter | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D. | | 22d. ADDRESS 606 Edmondson Ave. - 28 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/13/67 | 23c. NAME OF CEMETERY OR CREMATORY Cathedral | 23d. LOCATION (City, town, or county) Balt |
| 24. FUNERAL DIRECTOR'S SIGNATURE Farley Caronough | | 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE | |
| ADDRESS 6601 Frick Ave | | DATE FEB 15 1967 | |

01321

REPUBLIC OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01928

01924

| | | | | | | | |
|--|-------------------------------|--|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>GARRISON</u> | | c. LENGTH OF STAY IN 1b
<u>3 mo.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>DUNDALK.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>FOXLEIGH NURSING HOME</u> | | | | d. STREET ADDRESS
<u>60 YORKWAY</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Carl</u> Middle <u>Henning</u> Last <u>RENSTROM</u> | | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>22</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>Wh</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 22, 1879</u> | 9. AGE (in years last birthday)
<u>87</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Builder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Sweden</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Sweden</u> <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME
<u>Lars Renstrom</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Louise (unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>214-01-8826</u> | | 17. INFORMANT
<u>GEORGE RENSTROM</u> Address <u>60 YORKWAY.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>
<u>491X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Carcinoma of Prostate</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-26</u> , 19 <u>66</u> , to <u>2-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> , 19 <u>67</u> , and that death occurred at <u>2:10 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>David I. Miller</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>FEB 22-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>David I. Miller</u> | | | | 22d. ADDRESS
<u>Wison Rd.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/25/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>RURAL CEMETERY</u> | | 23d. LOCATION (City, town or county) (State)
<u>SOUTHBORO, MASS.</u> | |
| 24. FUNERAL DIRECTOR
<u>Walter Brooks Bradley, Inc.</u> | | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE
<u>FEB 24 1967</u> | | | | | | | |

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Caravan of Protest

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David Miller
David Miller

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

01929

01925

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Owings Mills</u> | | c. LENGTH OF STAY IN 1b
<u>15 yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hagerstown</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Rosewood State Hospital</u> | | | d. STREET ADDRESS
<u>1337 Marshall St.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Roy Lee Rhinehart</u> | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>23</u> Year <u>1967</u> | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/2/44</u> | 9. AGE (In years last birthday)
<u>22</u> yrs. | IF UNDER 1 YEAR
Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min. <u>22</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>none</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Hagerstown Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | 13. FATHER'S NAME
<u>Paul Franklin Rhinehart</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>LEAH Elizabeth Hlickenstaff</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
<u>Rosewood records, Rosewood State Hospital</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>asphyxia due to aspiration of</u>
<u>3255</u> DUE TO <u>Hard boiled Egg</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>mental Retardation</u>
(c) <u>microcephalic</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>45 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>microcephalic</u> | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>deceased grabbed a hard boiled egg & stuffed it in his mouth.</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>7:45 PM Feb 23 1967</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
<u>Rosewood State Hosp</u> | 20f. (City or town)
<u>Owings Mills</u> | (County)
<u>Bath.</u> | (State)
<u>Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<u>A.D. Caples</u> | | M.D.
<u>D.D. CAPLES, M.D.</u> | | 22. DATE SIGNED
<u>2-23-67</u> | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county)
<u>1337 Marshall St.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2-26-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Hagerstown, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Minnich Funeral Home, Hagerstown, Md.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 27 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01930

CERTIFICATE OF DEATH

01926

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
COCKEYSVILLE | | c. LENGTH OF STAY IN 1b
19 MONTHS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MASONIC HOME | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EMMA Middle M Last RICHARDSON | | 4. DATE OF DEATH
Month FEB Day 1 Year 1967 | |
| 5. SEX
FE | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/28/1883 |
| 9. AGE (In years last birthday)
83 yrs. | | 10. IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U-S | |
| 13. FATHER'S NAME
LEWIS T. BENNETT | | 14. MOTHER'S MAIDEN NAME
EMMA SILENCE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
213-46-2722 | |
| 17. INFORMANT
Masonic Home Record | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200
DUE TO 3 Bronchopneumonia Acute
DUE TO 3 arteriosclerotic heart disease
DUE TO 3 Cerebrovascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August , 19 66 , to Feb 2 , 19 67 , that (I) (we) last saw the deceased alive on Feb 2 , 19 67 , and that death occurred at 4:35 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
James H. Hamel MD | | 22b. DATE SIGNED
12/1/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JAMES H. HAMEL | | 22d. ADDRESS
MASONIC HOME | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
2-4-67 | 23c. NAME OF CEMETERY OR CREMATORY
LODGE PARK CEM. | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR
WM COOK BROOKS TOWSON | | 25a. REC'D BY REGISTRAR
1050 YORK RD TOWSON, MD 21204 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. DATE
FEB 6 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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REPORT OF
TO DIRECTOR
IN REPORT OF

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01931

CERTIFICATE OF DEATH

01927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD
c. LENGTH OF STAY IN TB
68 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
MIDDLE RIVER - 21 | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle A. Last RIDDICK | | 4. DATE OF DEATH
Month FEBRUARY Day 16 Year 1967 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/13/92 |
| 9. AGE (In years last birthday) yrs.
74 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
ELECTRICIAN LINEMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
ELECTRIC CO. | |
| 11. BIRTHPLACE (County & State, or foreign country)
AHOSKIE, NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
L. B. RIDDICK | | 14. MOTHER'S MAIDEN NAME
URETTA DUNN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
214 14 06 08 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RECURRENT RHABDOMYOSARCOMA OF RIGHT THIGH
1973
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) ADENOCARCINOMA OF SIGMOID COLON
(c) PNEUMONIA BILATERAL WITH METASTATIC NEOPLASM | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/10/66 , 19__, to 2/16/67 , 19__, that <input checked="" type="checkbox"/> (we) lost the deceased alive on 2/16/67 , 19__, and that death occurred on 9:45 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>George C. McElpatrick</i> | | 22b. DATE SIGNED
2/16/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE C. MC ELPATRICK, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/18/67 | 23c. NAME OF CEMETERY OR CREMATORY
Bohemian Nat. Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
SCHIMUNEK FUNERAL HOME
DATE FEB 20 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

01001

INVESTIGATION OF DEATH

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VERMONT ADULT INSTITUTION HOSPITAL

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U.S.A.

ARGENTINE, MOUNTAIN COUNTRY

ELIZABETH CO.

ELIZABETH HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01932

CERTIFICATE OF DEATH

01928

| | | | |
|---|------------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Port Howard | | c. LENGTH OF STAY IN 1b
18 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WALTER Middle (NMI) Last RIDDICK | | 4. DATE OF DEATH
Month FEBRUARY Day 17 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/1/98 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. IF UNDER 1 YEAR
Months - Days - Hours - Min. - | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Factory | |
| 11. BIRTHPLACE (County & State, or foreign country)
Providence, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Walter Riddick | | 14. MOTHER'S MAIDEN NAME
Elizabeth Sandler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWI | | 16. SOCIAL SECURITY NO.
212-09-60-69 | |
| 17. INFORMANT
Clinical Records, VAH, Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EMBOLISM
DUE TO 241X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CHRONIC COR PULMONALE
DUE TO
(c) BRONCHIAL ASTHMA AND EMPHYSEMA | | INTERVAL BETWEEN ONSET AND DEATH
MINUTES
2 YEARS
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. - | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that Dr. (this hospital) attended the deceased from Jan. 31 , 19 67 , to Feb. 17 , 19 67 , that he (we) last saw the deceased alive on Feb. 17 , 19 67 , and that death occurred at 7:40 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. Fabara | | 22b. DATE SIGNED
2/18/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JORGE A. FABARA, M.D. | | 22d. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/21/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Charles A. Rice | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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013383

Handwritten signature

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01933

CERTIFICATE OF DEATH

01929

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Baltimore 21234 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7507 Old Harford Rd. | | d. STREET ADDRESS
7507 Old Harford Rd. | |
| 3. NAME OF DECEASED (Type or print)
First SARAH Middle W. Last RI TMILLER | | 4. DATE OF DEATH
Month Feb. Day 20 Year 1967 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1896 Feb. 2, 1897 AGE (In years lost birthday) 73 yrs. 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
St. Louis, Mo. |
| 13. FATHER'S NAME
Julian White | | 14. MOTHER'S MAIDEN NAME
Martha E. ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-50-1308 | |
| 17. INFORMANT
Mr. Francis Hayes Ritmiller-7507 Old Harford Rd. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease
DUE TO Coronary atherosclerosis
(b) Hypertension RVD
DUE TO Drug reaction, 4/20/67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Obliterating arterial disease both lower extremities | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 , to Feb 20, 1967 , that (I) (we) last saw the deceased alive on Jan 20, 1967 , and that death occurred at 5:00 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. Donald W. Mintzer | | 22b. DATE SIGNED
Feb 20 1967 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
3009 Evergreen Ave., Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/23/67. | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc.-5305 Harford Rd., Balto. | | 25a. REC'D BY REGISTRAR
FEB 21 1967 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01032

CHARTER OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01934

CERTIFICATE OF DEATH

01930

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
7 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
725 West Barre Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Bertha Middle Robinson Last Robinson | | | | 4. DATE OF DEATH
Month February Day 1 Year 19 67 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Feb. 11, 1921 | |
| 9. AGE (In years last birthday) yrs.
45 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. | | | | 13. FATHER'S NAME | | | |
| 14. MOTHER'S MAIDEN NAME | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonay embolism, massive, acute
466X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Deep vein thrombosis, left leg
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
2 weeks | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Non-functioning left kidney - Cirrhosis (Laennec's) - Alcoholism, chr.
Azotemia - Thrombosed internal hemorrhoids with bleeding | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20a. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Jan. 24, 1967 to Feb. 1, 1967 , that (X) (we) lost the deceased alive on Feb. 1, 1967 , and that death occurred at 10:15 P. M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Anthony J. Young, M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2-2-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 2128 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Feb 6, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR
Charles A. Rice, 661 W. Barre St. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 6 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

01330

RECEIVED OF DEATH

1962

01330

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1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH </div> | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 01935 | | | | | 01931 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1717 Kurtz Avenue</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>
d. STREET ADDRESS <u>1717 Kurtz Avenue</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>William</u> Last <u>Roche</u> | | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>10</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>December 8, 1908</u> | | 9. AGE (In years last birthday) <u>58</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Supervisor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>G.L. Martin Co.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Charles Parnell Roche</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Lula E. Hetrick</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Family records</u> | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ca of Brain</u>
<u>1930</u> DUE TO (b) <u>Chloroblastoma multiforme</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1966</u> to <u>Feb 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 7, 1967</u> , and that death occurred at <u>7:45</u> M. , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>George T. Bulmaro</u> | | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 13, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Prospect Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Towson, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>John Burns' Sons, Towson, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | |

MEDICAL CERTIFICATION

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/10/01 BY 60322 UCBAW/BJS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01936

CERTIFICATE OF DEATH

01932

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | c. LENGTH OF STAY IN 1b
13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | d. STREET ADDRESS
3526 E. Fayette Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
ALBERT DWYER ROCKS | | | | 4. DATE OF DEATH Feb. 22 19 67
Month Day Year | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/26/02 | |
| 9. AGE (In years last birthday) yrs.
64 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Brewery Industry | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
John Rocks | | | |
| 14. MOTHER'S MAIDEN NAME
Maggie Dwyer | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | | |
| 16. SOCIAL SECURITY NO.
218 03 84 99 | | | | 17. INFORMANT Address
Clin. Rcds, VA Hospital, Ft Howard, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (SQUAMOUS CELL CARCINOMA)
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 9 , 19 67 , to Feb. 22 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 22 , 19 67 , and that death occurred at 8:30 A. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Carmelita A. Cendana | | | | 22b. DATE SIGNED
2-22-67 | | 22c. PHYSICIAN'S NAME (Type)
CARMELITA A. CENDANA, M.D. | |
| 22d. ADDRESS
VA Hospital, Fort Howard, Md. | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
2/27/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | 24. FUNERAL DIRECTOR
JOHN A. MORAN, INC. | |
| 25. REC'D BY REGISTRAR
Baltimore, Md. | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01338

01338

George A. Roberts

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01937

CERTIFICATE OF DEATH

01933

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| <u>Baltimore</u> | | <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>908 Overbrook Road</u> | | d. STREET ADDRESS
<u>908 Overbrook Road</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Francis Joseph Russell</u> | | 4. DATE OF DEATH
Month Day Year
<u>February 18, 1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 14, 1893</u> |
| 9. AGE (In years last birthday)
<u>73</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retail Clothing Salesman Clothing</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Clothing</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Charles Russell</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Powers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>216-07-8845</u> | |
| 17. INFORMANT
<u>Mrs. Catherine S. Russell</u> | | Address
<u>908 Overbrook Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> DUE TO
(c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>12 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1953</u> , to <u>18 Feb 1967</u> that (I) (we) last saw the deceased alive on <u>18 Feb 1967</u> , and that death occurred at <u>9 P.</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Charles H. Reier</u> | | 22b. DATE SIGNED
<u>20 Feb 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Charles H. Reier</u> | | 22d. ADDRESS
<u>6701 York Road</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>2/22/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>John A. Moran Inc. 3000 E. Baltimore St.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 24 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

LEP10

5230

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01938

01934

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTO - RURAL</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE - Rural</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>4 Comet Ct</u> | | d. STREET ADDRESS
<u>4 Comet Ct</u> | |
| 3. NAME OF DECEASED (Type or print) <u>JAMES William Samuels</u> | | 4. DATE OF DEATH <u>February 13 1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>17 April 40</u> |
| 9. AGE (In years last birthday) <u>26</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Sales Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Kitchens</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>David Samuels</u> | | 14. MOTHER'S MAIDEN NAME
<u>Marian Hughes</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes 1961-1962</u> | | 16. SOCIAL SECURITY NO.
<u>220-26-5914</u> | |
| 17. INFORMANT
<u>Mrs. David Samuels</u> | | Address
<u>Balto., Md. 21212</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Strangulation</u>
<u>9360</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
<u>TIGHTENING of leather slip knot about neck</u>
20c. TIME OF INJURY Month, Day, Year
<u>Under 1 a.m. 13 Feb 1967</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Home</u>
20f. (City or town) (County) (State)
<u>Balto.</u> | | INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED
<u>2-13-67</u> | |
| ACTUAL SIGNATURE
<u>John C. Hyle</u>
EXAMINER'S NAME (Type)
<u>JOHN C. Hyle</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county)
<u>Mt. Carmel, Penn.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 23b. DATE THEREOF
<u>2/4/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Carmel</u> | | 23d. LOCATION (City, town or county) (State)
<u>Mt. Carmel, Penn.</u> | |
| 24. FUNERAL DIRECTOR
<u>Farley Caranagh</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u>
25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u>
DATE
<u>FEB 15 1967</u> | |

18010

18010

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

VR A15 (4)
20 M 1/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 01939 | | 01935 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balt. 21207</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balt. 21207</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
<u>2615 N. Rolling Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>F. Estella Sauter</u> | | 4. DATE OF DEATH
Month Day Year
<u>Feb. 28 19 67</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/26/1875</u> |
| 9. AGE (In years last birthday)
<u>91</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Balt. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>David Kalb</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Long</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>21550-8848</u> | |
| 17. INFORMANT
<u>Mrs. Wm. H. Leishear-2615 N. Rolling Rd.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4500 Congestive Heart Failure</u>
DUE TO (b) <u>Arterio sclerosis</u>
DUE TO (c) <u>Diabetes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 months</u>
<u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Diabetes</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>60</u> , to <u>2/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>67</u> , and that death occurred at <u>10 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. Martin Ellin</u> | | 22b. DATE SIGNED
<u>3/1/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. Martin Ellin</u> | | 22d. ADDRESS
<u>8629 Liberty Rd. Randallstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/3/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>6 E. Franklin St. Balt. 2 Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>Jan 6 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

46610

05310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G385 2/20/67 pc

01940

CERTIFICATE OF DEATH

01936

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
43 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
1316 LIGHT STREET | |
| 3. NAME OF DECEASED (Type or print)
First BENJAMIN Middle M. Last SCEARCE | | 4. DATE OF DEATH
Month FEBRUARY Day 15 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/23/22 9. AGE (In years last birthday) 44 43 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHEET METAL WORKER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (Country & State, or foreign country)
DANVILLE, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
BENJAMIN SCEARCE | | 14. MOTHER'S MAIDEN NAME
EMMA BURNETT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
223 20 28 18 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LOWER LOBE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HODGKIN'S DISEASE
DUE TO
(c) — | | INTERVAL BETWEEN ONSET AND DEATH
RECENT
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (x) (this hospital) attended the deceased from 1/3/67 , 19 — , to 2/15/67 , 19 — , that (x) (we) last saw the deceased alive on 2/15/67 , 19 — , and that death occurred at 10:25AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
George Dudas | | 22b. DATE SIGNED
2/15/67 | |
| 22c. PHYSICIAN'S NAME (Type)
GEORGE DUDAS, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-17-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
Charles Fleming | | 25a. REC'D BY REGISTRAR
FLYNN & FLEMING FUNERAL HOME
DATE 1422 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. REGISTRAR'S SIGNATURE
1422 | |

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CHARTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01941

CERTIFICATE OF DEATH

01937

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE COUNTY
Reisterstown MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
CHAPEL HILL NURSING HOME | | d. STREET ADDRESS
Old Hanover Road | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Robert Schaeffer | | 4. DATE OF DEATH
Month 2 - Day 11 - Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 25, 1890 |
| 9. AGE (In years last birthday) yrs. 76 | | IF UNDER 1 YEAR
Months 13 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry C. Schaefer | | 14. MOTHER'S MAIDEN NAME
Anna Walter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-10-7956 | |
| 17. INFORMANT
Mrs. E. Grace Davis | | Address
Baltimore, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CVA
DUE TO
(c) Generalized Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pyelonephritis + Pyelonephrosis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-20-1967 , to 2-11-1967 , that (I) (we) last saw the deceased alive on 2-11-1967 , and that death occurred at 6:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Cesar Valle Cervero | | 22b. DATE SIGNED
2-11-67 | |
| 22c. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | | 22d. ADDRESS
3629 Liberty Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/14/67 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Gilead Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons | | 25a. REC'D BY REGISTRAR
FEB 16 1967 | |
| ADDRESS
Reisterstown, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01333

01334

DEPARTMENT OF HEALTH

1. Name of patient: [illegible]
2. Date of birth: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Address: [illegible]
6. City: [illegible]
7. State: [illegible]
8. Zip: [illegible]
9. Date of admission: [illegible]
10. Date of discharge: [illegible]
11. Date of death: [illegible]
12. Cause of death: [illegible]
13. Place of death: [illegible]
14. Date of autopsy: [illegible]
15. Name of pathologist: [illegible]
16. Name of attending physician: [illegible]
17. Name of hospital: [illegible]
18. Name of city: [illegible]
19. Name of state: [illegible]
20. Name of zip: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01942

CERTIFICATE OF DEATH

01938

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE
Maryland | | b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN 1b
14 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21210 | | 30-4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
911 W. Lake Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Rev. Carl F. SCHAPPERT | | First Middle Last | | 4. DATE OF DEATH
February 24, 19 67 | | Month Day Year | |
| 5. SEX
Male | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 16, 1886 | | 9. AGE (In years last birthday) yrs.
80 | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Religious PRIEST ROMAN CATHOLIC | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
GEORGE C. SCHAPPERT | | | | 14. MOTHER'S MAIDEN NAME
ELIZABETH STINGER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
REV. M. O'ROURKE 1130 N. CALVERT ST. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
DUE TO Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from 2/10/ , 19 67 , to 2/24/ , 19 67 that (X) (we) last saw the deceased alive on 2/24/ , 19 67 , and that death occurred at 12:08M , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Reynaldo Orjuella - Gomez | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
P. | | 22b. DATE SIGNED
February 24, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Reynaldo Orjuella - Gomez | | | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
3/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. MARY'S CEMETERY WILKES-BARRE, PENNA | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
N.W. MEARS & SON 805 N. CALVERT ST. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 2 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01938

01938

| | | | |
|--------------|--|--------------|--|
| 1. Name | | 2. Address | |
| 3. City | | 4. State | |
| 5. Zip | | 6. Telephone | |
| 7. Date | | 8. Time | |
| 9. Signature | | 10. Initials | |
| 11. Remarks | | 12. Remarks | |
| 13. Remarks | | 14. Remarks | |
| 15. Remarks | | 16. Remarks | |
| 17. Remarks | | 18. Remarks | |
| 19. Remarks | | 20. Remarks | |
| 21. Remarks | | 22. Remarks | |
| 23. Remarks | | 24. Remarks | |
| 25. Remarks | | 26. Remarks | |
| 27. Remarks | | 28. Remarks | |
| 29. Remarks | | 30. Remarks | |
| 31. Remarks | | 32. Remarks | |
| 33. Remarks | | 34. Remarks | |
| 35. Remarks | | 36. Remarks | |
| 37. Remarks | | 38. Remarks | |
| 39. Remarks | | 40. Remarks | |
| 41. Remarks | | 42. Remarks | |
| 43. Remarks | | 44. Remarks | |
| 45. Remarks | | 46. Remarks | |
| 47. Remarks | | 48. Remarks | |
| 49. Remarks | | 50. Remarks | |
| 51. Remarks | | 52. Remarks | |
| 53. Remarks | | 54. Remarks | |
| 55. Remarks | | 56. Remarks | |
| 57. Remarks | | 58. Remarks | |
| 59. Remarks | | 60. Remarks | |
| 61. Remarks | | 62. Remarks | |
| 63. Remarks | | 64. Remarks | |
| 65. Remarks | | 66. Remarks | |
| 67. Remarks | | 68. Remarks | |
| 69. Remarks | | 70. Remarks | |
| 71. Remarks | | 72. Remarks | |
| 73. Remarks | | 74. Remarks | |
| 75. Remarks | | 76. Remarks | |
| 77. Remarks | | 78. Remarks | |
| 79. Remarks | | 80. Remarks | |
| 81. Remarks | | 82. Remarks | |
| 83. Remarks | | 84. Remarks | |
| 85. Remarks | | 86. Remarks | |
| 87. Remarks | | 88. Remarks | |
| 89. Remarks | | 90. Remarks | |
| 91. Remarks | | 92. Remarks | |
| 93. Remarks | | 94. Remarks | |
| 95. Remarks | | 96. Remarks | |
| 97. Remarks | | 98. Remarks | |
| 99. Remarks | | 100. Remarks | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01939

| | | | | | |
|---|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
EAST POINT | | | c. LENGTH OF STAY IN 1b
03-1 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7727 E. Baltimore St. | | | d. STREET ADDRESS
7727 E. Baltimore St. | | |
| 3. NAME OF DECEASED
(Type or print)
First LAURA Middle SCHRADER Last SCHRADER | | | 4. DATE OF DEATH
Pronounced February 25, 19 67 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/5/59 | 9. AGE (In years lost birthday) yrs.
7 | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
MD | |
| 13. FATHER'S NAME
DONALD SCHRADER | | | 14. MOTHER'S MAIDEN NAME
PHYLLIS BARLOW | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
_____ | | 17. INFORMANT Address
ELEANOR MEMODA 284-0246 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
9160 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Carbon monoxide DUE TO
(c) Conflagration | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fire in row house | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour XX 11:40 p.m. 2-24 19 67 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| | | 20f. (City or town) (County) (State)
Baltimore Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Charles S. Springate | | M.D.
Charles S. Springate, M.D. | | 22. DATE SIGNED
February 27, 1967 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/28/67 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | ADDRESS
300 MACE | | 25a. REC'D BY REGISTRAR
DATE MAR 1 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01330

01330

01330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(N)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01944

CERTIFICATE OF DEATH

01940

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Baltimore, Md. b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital, Towson, Md. 21204 | | d. STREET ADDRESS
3710 Raspe Avenue | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle R. Last SCHUELER | | 4. DATE OF DEATH
Month Feb. Day 19 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
5-7-1891 |
| 9. AGE (In years last birthday) yrs.
75 | | IF UNDER 1 YEAR
Months — Days — Hours — Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tailor | | 10b. KIND OF BUSINESS OR INDUSTRY
Grief Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Dudley | | 14. MOTHER'S MAIDEN NAME
Victoria Ramsone | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Patient on admission | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 151X
DUE TO Carcinoma of the stomach
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour — a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2-9 , 19 67 , to 2-19 , 19 67 , that (I) (we) last saw the deceased alive on 2-19 , 19 67 , and that death occurred at 1:05 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Regalado Dizon | | 22b. DATE SIGNED
2-19-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Regalado Dizon, M.D. | | 22d. ADDRESS
7620 York Road, Baltimore, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2-22-67 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Park | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
John C. Miller Inc. - 6415 Belair Road - 21206 | | 25a. REC'D BY REGISTRAR
FEB 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

012340

012340

10/1/50

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10/1/50

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

| <div style="display: flex; justify-content: space-between;"> <div> <p>1
01945</p> </div> <div> <p>3
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH</p> </div> <div> <p>01941</p> </div> </div> | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>
c. LENGTH OF STAY IN 1b <u>33 yrs.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>101 Sherwood ave</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>
d. STREET ADDRESS <u>101 Sherwood ave</u>
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Henry David Sharrer</u> | | | | | | 4. DATE OF DEATH
Month Day Year
<u>Feb 15 1967</u> | | | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct 12, 1887</u> | | 9. AGE (In years last birthday) <u>79</u> yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>chips</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Taneytown, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>David H. Sharrer</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Sophia Heck</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>218-32-1255</u> | | 17. INFORMANT
Address <u>101 Sherwood ave Pikesville, Pa.</u>
<u>Mrs. Beulah Sharrer</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of right lung</u>
163X DUE TO
Conditions, if any, which gave rise to immediate cause (b) DUE TO
(a), stating the underlying cause last. (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1967</u> to <u>Feb 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 14, 1967</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Paul H Royse</u> M.D. | | | | | | 22b. DATE SIGNED
<u>Feb 15, 1967</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>PAUL H. ROYSE</u> | | | | | | 22d. ADDRESS
<u>1403 Foley La. Pikesville, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2-18-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olivet Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Hanover, York Co. Pa.</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Tipton - Eline Funeral Home Hampstead, Md.</u> | | | | | | 25. REC'D BY REGISTRAR
<u>FEB 20 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

10010

CERTIFICATE OF DEATH

10010

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01946

CERTIFICATE OF DEATH

01942

| | | | | | |
|--|---------------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN TB
<u>3 yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lusby</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Forest Haven Nursing Home</u> | | | d. STREET ADDRESS
<u>Box 8</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First <u>Florence</u> Middle <u>H.</u> Last <u>Simmerman</u> | | | 4. DATE OF DEATH
Month <u>Feb</u> Day <u>23</u> Year <u>1967</u> | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAR. 14, 1872</u> | 9. AGE (In years last birthday)
<u>94</u> yrs. | IF UNDER 1 YEAR
Months <u>23</u> Days <u>19</u> Hours <u>67</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Salem, N.J.</u> | |
| 13. FATHER'S NAME
<u>William Dikes</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
Address <u>Phila. Mrs. Mabel Mowrey 744 Sommers Road, PA.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HEMIPLEGIC-SCIENTIFIC CARNIE-UNUSUAL</u>
4221 DUE TO
(b) <u>MISFEAR, E. GENERAL UNUSUAL</u>
DUE TO
(c) <u>PULMONARY OEDEMA - PNEUMONIA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>66</u> , to <u>2/23</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>2/22</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M, from causes on and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>John H. Shaw M.D.</u> | | 22b. DATE SIGNED
<u>2/23/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>John H. Shaw M.D.</u> | |
| 22d. ADDRESS
<u>5505 EMBROIDERER AVE. #04-28, MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>2/26/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Fernwood Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Reversford, Montgomery, Pa.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Easton Funeral Home Catonsville, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 2 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

0105

32210

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01947

CERTIFICATE OF DEATH

01943

| | | | | | | | |
|--|------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Balt.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Randallstown</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21207 MD</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Baltimore County General</u> | | | | d. STREET ADDRESS
<u>3415 Mayfair Road</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>E.</u> Middle <u>Skinner</u> Last | | | | 4. DATE OF DEATH
Month <u>2</u> Day <u>4</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>April 22, 1907</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Self Employed Laundry</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Miss.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>Frank Skinner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Marguerite ?</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO.
<u>175-01-9610A</u> | | 17. INFORMANT
<u>Theodore L. Skinner</u> Address <u>3415 Mayfair Rd</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiovascular Failure</u>
DUE TO <u>5271</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Or Pulmonary</u>
DUE TO (c) <u>Emphysema + Bronchial asthma</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)
<u>Pneumonia, etc. of Lung (aspirated)</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-2</u> , 19 <u>67</u> to <u>2-4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Angelita Topano</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-4-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ANGELITA TOPANO M.D.</u> | | | | 22d. ADDRESS
<u>PCDH</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Buried</u> | | 23b. DATE THEREOF
<u>2-7-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Abington Hills</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Chinchilla, Pa.</u> | |
| 24. FUNERAL DIRECTOR
<u>Young Bros 8728 Liberty Rd. Randallstown</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04010

13210

RECEIVED
JANUARY 10 1960
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01948

CERTIFICATE OF DEATH

01944

| | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Relay
c. LENGTH OF STAY in lb
two yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
e. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
XXXXXXXX Relay
d. STREET ADDRESS
701 Gun Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Sister Mary Cyrilla Smith | | | | 4. DATE OF DEATH
Month Day Year
2 6 1967 | | | | | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 13, 1893 | | 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country)
Topeka, Kansas | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
George Smith | | | | 14. MOTHER'S MAIDEN NAME
Sarah Hamilton | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
220560134 | | | | 17. INFORMANT
Sr. M. Magdalen Address 701 Gun Rd. Balto. Md. | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Chronic Renal Insufficiency
603X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH one year | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 1965 to Feb 6, 1967 that (I) (we) last saw the deceased alive on Jan 4 1967 and that death occurred at 11:29 AM , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Emidio A. Bianco
M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Emidio A. Bianco | | | | | | 22d. ADDRESS
3350 Wilkens Ave 21229 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
Feb 9/67 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem | | | | 23d. LOCATION (City, town or county) (State)
4300 Old Fredrick Road | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Zorah W. Elickson | | | | | | ADDRESS
1129 N. Caroline St | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1967 | | 25b. REGISTRAR'S SIGNATURE
quinn's judge | | | | | |

1990

25010

2009-10-17 New Orleans, LA 70112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01949

CERTIFICATE OF DEATH

01945

| | | | |
|---|----------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
38yr4mth27dys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore City | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital 1 | | d. STREET ADDRESS
Almshouse | |
| 3. NAME OF DECEASED
(Type or print)
First Mary Middle Smo Last nick | | 4. DATE OF DEATH
Month February Day 15 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1891 |
| 9. AGE (In years last birthday) yrs.
76 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Galicia, Poland | | 12. CITIZEN OF WHAT COUNTRY?
Poland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
219-54-3434 | |
| 17. INFORMANT
Spring Grove State Hospital: Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Bilateral pneumonia | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (x)(this hospital) attended the deceased from 9-18-28 , 18 to Feb. 15, 1967 , that (I) (we) last saw the deceased alive on Feb. 15 19 67 , and that death occurred at 9:55 A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Evelio Felipe</i> | | 22b. DATE SIGNED
2-15-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Evelio Felipe, M.D. | | 22d. ADDRESS
Spring Grove State Hospital
Catonsville, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-20-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Old French Road/Balto Md | |
| 24. FUNERAL DIRECTOR
Krause Funeral Home 1216 S Charles St | | 25a. REC'D BY REGISTRAR
DATE FEB 23 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

01945

01945

California State Hospital
San Jose, California

San Jose State Hospital

San Jose State Hospital
San Jose, California

San Jose State Hospital

San Jose State Hospital

San Jose State Hospital
San Jose, California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

4

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01950

CERTIFICATE OF DEATH

01946

| | | | | | | | |
|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | | c. LENGTH OF STAY IN 1b
2yrlmth3dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 5926 Charles Street
2511 West Lombard St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First John Middle H. Last Smyth | | | | 4. DATE OF DEATH
Month February Day 10 Year 19 67 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
1884 9-14-84 | | 9. AGE (In years last birthday) yrs.
82 | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Smyth | | | | 14. MOTHER'S MAIDEN NAME
Dorothy Sprunger | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
218-10-3163 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
193X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerosis, generalized and severe | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Jan. 7, 1965 to Feb. 10, 1967 , that (X) (we) last saw the deceased alive on Feb. 10, 1967 , and that death occurred at 12:25 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachler | | a. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-10-67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachler, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-13-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
3801 Frederick Ave, Balto.Md. | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | 25a. REC'D BY REGISTRAR
FEB 14 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

2468

0750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01951

CERTIFICATE OF DEATH

01947

| | | | |
|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
<u>BALTIMORE</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>MD.</u>
b. COUNTY
<u>PRINCE GEORGE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN 1b
<u>4-YEARS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>GLENN DALE</u> | | 16-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE HOSPITAL</u> | | d. STREET ADDRESS
<u>ROUTE #1-BOX #139</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>AGNES REBECCA SNOWDEN</u> | | 4. DATE OF DEATH
Month Day Year
<u>2 14 1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-16-86</u> |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NURSE'S AID</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>HOSPITAL</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>WASHINGTON D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>LEONARD HERBERT</u> | | 14. MOTHER'S MAIDEN NAME
<u>THEREIA NEAL</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>220-03-1732</u> | |
| 17. INFORMANT
<u>EUGENE SNOWDEN-SAME AS PT'S</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO
(c) <u>YEARS</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>MINUTES</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-27, 1963</u> to <u>2-14, 1967</u> , that (I) (we) last saw the deceased alive on <u>2-14, 1967</u> , and that death occurred at <u>2:24</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Rolando Vieta</u> | | 22b. DATE SIGNED
<u>2-14-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROLANDO VIEITA</u> | | 22d. ADDRESS
<u>SPRING GROVE ST. HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>2/18/1967</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>HOLY FAMILY CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Mitchellville Va</u> | |
| 24. FUNERAL DIRECTOR
<u>Alfred S. Pope, Jr.</u> | | 25a. REC'D BY REGISTRAR
<u>414-15th St S.E.</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>FEB 16 1967</u> | |

01947

DEPARTMENT OF DEATH

01947

MC

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1947-01-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
2DM 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---|---|--|--|--|---|---|--|
| 01952 | | | | | 01948 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Catonville</u> | | | c. LENGTH OF STAY IN 1b
<u>7 Days</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Edgemere</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Summit Nursing Home</u> | | | | | d. STREET ADDRESS
<u>Chesapeak Ave. Rt. 10 Box 19X</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Middle</u> <u>Sohn</u> Last | | | | | 4. DATE OF DEATH <u>Feb. 8,</u> 19 <u>67</u> Month Day Year | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | B. DATE OF BIRTH <u>May 13, 1887</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clothing Cutter</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Schloss Bros. Co.</u> | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Sohn</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Raab</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<u>215-01-8561</u> | | 17. INFORMANT <u>Box 19 X</u> Address <u>Balto. 19, Md.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vase dis</u>
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Uremia</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> , 19 <u>67</u> to <u>2-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-6</u> , 19 <u>67</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>I. EARL PASS</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>2-8-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u> | | | | | 22d. ADDRESS <u>4000 Wilkens Ave</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 10, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cem.</u> | | 23d. LOCATION (City, town or county) <u>Balto. Md.</u> (State) _____ | | | |
| 24. FUNERAL DIRECTOR <u>G. Truman Schwab</u> ADDRESS <u>3512 Frederick Ave. Balto. Md.</u> | | | | | 25a. REC'D BY REGISTRAR <u>10</u> DATE <u>1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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DM 115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|------------------------------|---|--|-------------------------------------|--|---|--|--|--------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 01953 | | | | | 01949 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>NORTH CAROLINA</u> b. COUNTY <u>ASHEVILLE</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>TOWSON</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>ASHEVILLE</u> | | | d. STREET ADDRESS
<u>5 CALADONIA ROAD</u>
<u>6701 N. CHARLES ST.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>GREATER BALTO MEDICAL CENTER</u> | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) | | First | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year |
| | | <u>SUSAN</u> | <u>WALKER</u> | <u>SPALDING</u> | | | <u>2-</u> | <u>15-</u> | <u>19 67</u> |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>11-18-76</u> | | 9. AGE (In years last birthday)
<u>90</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOMEMAKER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>ROMNEY W. VIRGINIA</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>HOLDRIDGE CHIDESTER</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>HANNA SUSAN WALKER</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>213-05-4920</u> | | 17. INFORMANT
Address
<u>RICHARD N. WILLS, McDONOUGH, Md.</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> , 19 <u>67</u> to <u>2-15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2-15</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Manuel V. Gatchalian</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>2-15-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MANUEL V. GATCHALIAN</u> | | | | | 22d. ADDRESS
<u>6701 N. CHARLES ST</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>2/16/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge</u> | | 23d. LOCATION (City, town or county) (State)
<u>Pikesville, Balto. Co. Md</u> | | |
| 24. FUNERAL DIRECTOR
<u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 16 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G385 2/8/67 mh
Item #4 Film #G389 8/15/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---|--|--|
| 01954 | | 01950 | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY Harford <i>BALTO.</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson <i>03-1</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1705 Aberdeen Rd. | | d. STREET ADDRESS
1705 Aberdeen Rd. | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle Walter Last SPEAR | | 4. DATE OF DEATH
Month February Day 1 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> separated | 8. DATE OF BIRTH
3-15-1918 |
| 9. AGE (In years last birthday)
48 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 9 Hours 49 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Capt. Tyler W. Spear | | 14. MOTHER'S MAIDEN NAME
Helen M. Wagner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes WW 2 | | 16. SOCIAL SECURITY NO.
WW 2 | |
| 17. INFORMANT
Mrs Helen Eisenhardt | | Address
same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 Occlusive coronary arteriosclerotic heart disease.
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Rudiger Breiteneker, M.D. | | 22. DATE SIGNED
2/2/67 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
2-4-67 | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Leonard J. Kuck, Inc Baltimore, Md. | | 25a. REC'D BY REGISTRAR
Feb 6 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01955

CERTIFICATE OF DEATH

01951

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md b. COUNTY Baltimore Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE 03-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SUMMIT NURSING HOME | | d. STREET ADDRESS
19 N. Belle Grove Rd | |
| 3. NAME OF DECEASED (Type or print)
First ANNA Middle E. Last SPICES | | 4. DATE OF DEATH
Month 2 - Day 17 - Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
OCT. 28, 1893 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) 73 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Reinhold F. Tribull | | 14. MOTHER'S MAIDEN NAME
Elizabeth Richstein | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
216-05-2247 | |
| 17. INFORMANT
Mrs. CARROLL T. Giese Sr. | | Address
CATONSVILLE MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardio-Vascular Disease DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
14 da.
10 yr. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3-11-1937 , to 2-17-1967 , that (I) (we) lost the deceased alive on 2-16-1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wilmer K. Gallagher Sr. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Wilmer K. Gallagher Sr. | | 22d. ADDRESS
6209 Frederick Ave. Balt. 21228 Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2-20-67 | 23c. NAME OF CEMETERY OR CREMATORY
Louisa Pk. Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. |
| 24. FUNERAL DIRECTOR
E. S. Mac Nabb | | 25a. REC'D BY REGISTRAR
21 FEB 21 1967 | |
| ADDRESS
301 Frederick Rd Baltimore Md. 21208 | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01256

01256

STATE OF NEW YORK
IN SENATE
January 12, 1933
REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
FOR THE YEAR
1932

ALBANY: J.B. LIPPINCOTT COMPANY, PRINTERS
1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Pa. b. COUNTY 75-3 | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Philadelphia | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Dulaney Towson Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Emma Middle J. Last Stahl | | 4. DATE OF DEATH
Month February Day 7 Year 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/11/1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 9. AGE (in years last birthday) 77 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country)
Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Trimborn | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
163-10-3320 | |
| 17. INFORMANT
William H. Stahl, 15 Murray Hill Circle | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
1 week
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/21 , 19 66 , to 2/7 , 19 67 , that (I) (we) last saw the deceased alive on 2/3 , 19 67 , and that death occurred at 11:30 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. F. Cox | | 22b. DATE SIGNED
Feb 67 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. William F. Cox, III | | 22d. ADDRESS
1118 St. Paul St. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Rem.-Burial | | 23b. DATE THEREOF
2/10/1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Peter's Luth. Ch. Cem. | | 23d. LOCATION (City, town or county) (State)
Lafayette Hill, Pa. | |
| 24. FUNERAL DIRECTOR
H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
Feb 10 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0195A

CERTIFICATE OF DEATH

01954

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>LANSDOWNE</u> | | c. LENGTH OF STAY IN 1b
<u>12 YRS.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>2430 Zion Road</u> | | d. STREET ADDRESS
<u>2430 Zion Road.</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>William George Stapf</u> | | 4. DATE OF DEATH
Month Day Year
<u>Feb. 20 1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>JAN 14, 1900</u> |
| 9. AGE (In years last birthday)
<u>67</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Butcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MEAT PACKING</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George Stapf</u> | | 14. MOTHER'S MAIDEN NAME
<u>Barbara Hoffman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>216-03-0957</u> | |
| 17. INFORMANT
<u>Ruth Peters</u> | | Address
<u>2430 Zion Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u>
DUE TO (c) <u>Arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>January</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>February 20</u> 19 <u>67</u> , and that death occurred at <u>1 P.</u> M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. S. Stenley</u> | | 22b. DATE SIGNED
<u>2/20/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Francis W. Miller</u> | | 22d. ADDRESS
<u>2101 Frederick Ave</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>2-23-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>LONDON PARK</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>BALTIMORE Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Francis W. Miller</u> | | 25a. REC'D BY REGISTRAR
<u>FEB 23 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01951

RECEIVED BY BUREAU

01951

RECEIVED BY BUREAU
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01959

CERTIFICATE OF DEATH

01955

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. LENGTH OF STAY IN 1b
<u>SINCE 1956</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Good Women's & Men's Homes</u> | | | | d. STREET ADDRESS
<u>2735 N. Calvert St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Louise</u> Middle <u>Steinmetz</u> Last _____ | | | | 4. DATE OF DEATH
Month <u>February</u> Day <u>7</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 10, 1877</u> | 9. AGE (In years last birthday)
<u>89</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John George Blum</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>?</u> <u>Kraft</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
_____ | | 17. INFORMANT
<u>Frances Strickfus</u> Address <u>615 Chestnut</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchitis - Pneumonia</u>
<u>4221</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>ASCD with Cardiac Failure</u> DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1958</u> , to <u>Feb. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb. 7, 1967</u> , and that death occurred at <u>2 p.m.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Newland E. Day</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>February 8, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Newland E. Day, M.D.</u> | | | | 22d. ADDRESS
<u>4-E-33rd St Baltimore Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Feb. 9, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

01929

01929

RECEIVED OF DEATH

Franklin D. Roosevelt
1945

4 days
1945

March 3 Day

4-2-55

February 2nd
1945

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01960

01956

| | | | |
|--|-----------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Howard</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | d. STREET ADDRESS <u>5706 Lawyers Hill Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Hilda</u> First <u>Kirk</u> Middle <u>Jones</u> Last <u>Stevens</u> | | 4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Caw</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-3-01</u> - <u>01</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Chester, Penna</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Hammon Kirk</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Chadwick</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>214-56-0101</u> | |
| 17. INFORMANT <u>PATIENT'S CHART</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure.</u>
172X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Hemorrhage from necrotic @ hypogastric artery</u>
DUE TO
(c) <u>Endometrial carcinoma, radiation therapy & surgery.</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 3</u> , 19 <u>67</u> , to <u>Feb. 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 6</u> , 19 <u>67</u> , and that death occurred at <u>12:40</u> PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Robert W. Smith</u> M.D. | | 22b. DATE SIGNED <u>2-6-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>2-8-1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Grace Episcopal Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Elkridge, Howard County, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | 25. REC'D BY REGISTRAR <u>FEB 9 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0130

25703

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page 4

12-1-2

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01961

CERTIFICATE OF DEATH

01957

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>_____</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>City of Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>College Manor</u> | | d. STREET ADDRESS
<u>1533 Bolton Street</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Anna</u> Middle <u>Berkeley</u> Last <u>Stevenson</u> | | 4. DATE OF DEATH
Month <u>2</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 1, 1868</u> |
| 9. AGE (In years last birthday)
<u>98</u> yrs. | | IF UNDER 1 YEAR
Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min. <u>_____</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>NONE</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Prob. Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>_____</u> | |
| 13. FATHER'S NAME
<u>WILLIAM HENRY STEVENSON</u> | | 14. MOTHER'S MAIDEN NAME
<u>FANNY MADISON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>214-54-3369</u> | |
| 17. INFORMANT: <u>Dec'd. Atty.:</u> Address
<u>(& Dec'd.) Hinkley & Singley, Balto., Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>492X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>_____</u>
DUE TO
(c) <u>_____</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>ASHD</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>_____</u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1st, 1960</u> , to <u>Feb 21, 1967</u> , that (I) last saw the deceased alive on <u>Feb 21, 1967</u> , and that death occurred at <u>10:10 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W. Dugan</u> | | 22b. DATE SIGNED
<u>2/21/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. DUGAN</u> | | 22d. ADDRESS
<u>15 E BIDDLE ST BALTIMORE MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>Feb. 24, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Green Mount Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Stewart & Mowen Co. 108 W. North Av., City 1</u> | | 25a. REC'D BY REGISTRAR
<u>DATE FEB 23 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

52910

3020

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01962

CERTIFICATE OF DEATH

01958

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. LENGTH OF STAY in 1b
8 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | d. STREET ADDRESS
5403 North Ave & Jackson St. | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle EWING Last STEWART | | 4. DATE OF DEATH
Month February Day 22 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
9/19/19 |
| 9. AGE (In years last birthday)
47 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 16 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY
Electrician | |
| 11. BIRTHPLACE (County & State, or foreign country)
Easton, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Stewart | | 14. MOTHER'S MAIDEN NAME
Josephine Ewing | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WWII | | 16. SOCIAL SECURITY NO.
WWII | |
| 17. INFORMANT
Clinical Rcds. VA Hospital, Ft Howard, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER
5810
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
DUE TO
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
BILATERAL LOBAR PNEUMONIA | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____
p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 14 , 19 67 to Feb. 22 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 22 , 19 67 , and that death occurred at 10:50 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
J. D. Talbert | | 22b. DATE SIGNED
2/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | 22d. ADDRESS
VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/25/1967 | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____
Easton, Md. |
| 24. FUNERAL DIRECTOR
NEWNAM Funeral Home | | 25a. REC'D BY REGISTRAR
FEB 27 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01028

GENERAL OF DEATH

01028

1. NAME: [illegible]
2. DATE OF BIRTH: [illegible]
3. PLACE OF BIRTH: [illegible]
4. SEX: [illegible]
5. OCCUPATION: [illegible]
6. RELIGION: [illegible]
7. MARITAL STATUS: [illegible]
8. EDUCATION: [illegible]
9. SERVICE RECORD: [illegible]
10. MEDICAL HISTORY: [illegible]
11. SOCIAL HISTORY: [illegible]
12. PSYCHOLOGICAL HISTORY: [illegible]
13. PHYSICAL EXAMINATION: [illegible]
14. LABORATORY TESTS: [illegible]
15. TREATMENT: [illegible]
16. PROGNOSIS: [illegible]
17. DISPOSITION: [illegible]
18. SIGNATURE: [illegible]
19. DATE: [illegible]
20. PLACE: [illegible]

100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8, 9 Film G385 2/15/67 mb

FOR STATE
HEALTH DEPT.

01963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01959

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Hall
c. LENGTH OF STAY IN 1b
2 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4006 Pinedale Drive | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Perry Hall
d. STREET ADDRESS
4006 Pinedale Drive
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) Edmund Sylvester Stillmock
First Middle Last
4. DATE OF DEATH
Feb. 7, 1967
Month Day Year | | | | 5. SEX
Male
6. COLOR OR RACE
Caucasian
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
Feb. 10, 1921
9. AGE (In years last birthday)
45 4/4
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Weather Analyst
11. BIRTHPLACE (State or foreign country)
Gr. Omaha, Neb.
12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Martin Stillmock
15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes
16. SOCIAL SECURITY NO.
WW11 - 1958
17. INFORMANT
Winifred N. Stillmock
Address
4006 Pinedale Dr. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatic Cardiovascular Disease
416X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work ot work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
ACTUAL SIGNATURE John C. Hyle M.D.
EXAMINER'S NAME (Type) John C. Hyle M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7527 Belair Rd.
Address (Street, city, town, or county) Overlea 2/7/67
22. DATE SIGNED | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial
23b. DATE THEREOF
Feb. 10, 67
23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. Catonsville Md.
23d. LOCATION (City or Town) (County) (State) | | | | 24. FUNERAL DIRECTOR
Dippel Brothers Inc. 7110 Belair Rd.
ADDRESS
25a. REC'D BY REGISTRAR
99
DATE
1967
25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18-21, Film Q388 5/15/67

01960

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson-rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson-rural | |
| c. LENGTH OF STAY IN 1b
3 YEARS | | d. STREET ADDRESS
924 Starbit Rd | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Greater Baltimore Medical Center | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Charles DANCAN Strawbridge | | 4. DATE OF DEATH
Month Day Year
2 18 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JUNE 29, 1963 |
| 9. AGE (In years last birthday) yrs.
3 4 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NEVER EMPLOYED | | 10b. KIND OF BUSINESS OR INDUSTRY
None | |
| 11. BIRTHPLACE (State or foreign country)
WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
F. NEILSON STRAWBRIDGE | | 14. MOTHER'S MAIDEN NAME
CONSTANCE BOWIE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
F. NEILSON STRAWBRIDGE | | Address
SAME AS 2-D | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural hemorrhage
902.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell from chair or high stool on 2-12-67 | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 2-12- 19 67
p.m. ? | 20d. INJURY OCCURRED 2
While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | 20f. (City or town) (County) (State)
Baltimore Baltimore Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D.
EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | |
| 22. DATE SIGNED
2/19/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial Cremation | 23b. DATE THEREOF
2-20-67 | 23c. NAME OF CEMETERY OR CREMATORY
GREENMOUNT CREMATORY | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
Wm. Cook - Brackstensen | | 25a. REC'D BY REGISTRAR
2004 | |
| 25b. REGISTRAR'S SIGNATURE
John A. Jones | | DATE
FEB 21 1967 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>01965</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>01961</p> </div> </div> | | | | | | | | | | | |
|--|--|--------------------------------------|--|---|---|--|--|---|--|---|--|
| <p>1. PLACE OF DEATH BALTIMORE COUNTY</p> <p>a. COUNTY</p> <p>GREATER BALTIMORE MEDICAL CENTER</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p>BALTIMORE</p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p>GREATER BALTIMORE MEDICAL CENTER</p> | | | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE MARYLAND b. COUNTY HARFORD</p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</p> <p>BELAIR</p> <p>d. STREET ADDRESS</p> <p>ROUTE 1 BOX 61</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | | |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First MILTON E. Middle STREET Last STREET</p> | | | | | | <p>4. DATE OF DEATH</p> <p>Month FEB. Day 26 Year 1967</p> | | | | | |
| <p>5. SEX MALE</p> | | <p>6. COLOR OR RACE CAUC.</p> | | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | <p>8. DATE OF BIRTH 3-04-01</p> | | <p>9. AGE (In years last birthday) 65 yrs.</p> | | <p>IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p>Months Days Hours Min.</p> | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Plaster--Farmer</p> | | | | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>Const. & Farm</p> | | <p>11. BIRTHPLACE (County & State, or foreign country)</p> <p>HARFORD CO., MD</p> | | <p>12. CITIZEN OF WHAT COUNTRY?</p> <p>U.S.</p> | | | |
| <p>13. FATHER'S NAME</p> <p>RICHARD M. STREET</p> | | | | | | <p>14. MOTHER'S MAIDEN NAME</p> <p>BULL Ella Bull</p> | | | | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p> | | | | <p>16. SOCIAL SECURITY NO.</p> <p>212-18-9179-A</p> | | <p>17. INFORMANT Address</p> <p>Wife, Same as 2 C & D</p> | | | | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Acute Cor Pulmonale</p> <p>2001 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma of mediastinum</p> <p>DUE TO (c)</p> | | | | | | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | | | | | | | | | |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p> | | | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. 19</p> | | | | <p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) (County) (State)</p> | | | |
| <p>21. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1967, to Feb. 26, 1967, that (I) (we) last saw the deceased alive on Feb. 26, 1967, and that death occurred at 10 AM, from the causes and on the date stated above.</p> | | | | | | | | | | | |
| <p>22a. SIGNATURE</p> <p>C. C. SHIH</p> | | | | | | <p>22b. DATE SIGNED</p> <p>Feb. 26, 1967</p> | | | | | |
| <p>22c. PHYSICIAN'S NAME (Type)</p> <p>C. C. SHIH MD.</p> | | | | | | <p>22d. ADDRESS</p> <p>Greater Balto. Med. Center</p> | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p>Burial</p> | | | <p>23b. DATE THEREOF</p> <p>1 Mar. 67</p> | | <p>23c. NAME OF CEMETERY OR CREMATORY</p> <p>Rock Run Cemetery</p> | | | <p>23d. LOCATION (City, town or county) (State)</p> <p>Havre de Grace, Md.</p> | | | |
| <p>24. FUNERAL DIRECTOR</p> <p>Walter H. Kerschbaum Jr.</p> | | | | | | <p>25b. REGISTRAR'S SIGNATURE</p> <p>Charles Judge</p> | | | | | |
| <p>25a. REC'D BY REGISTRAR</p> <p>DATE MAR 1 1967</p> | | | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01966

01962

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
c. LENGTH OF STAY IN 1b
03-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6010 Moorehead Rd. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville
d. STREET ADDRESS
6010 Moorehead Rd.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle T. Last Strehlau | | 4. DATE OF DEATH
Month Feb. Day 6 Year 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
Wh | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-12-94 |
| 9. AGE (In years last birthday) yrs.
72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | 11. BIRTHPLACE (County & State, or foreign country)
Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Frederick Strehlau | |
| 14. MOTHER'S MAIDEN NAME
Nellie Sauner | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
215-03-4799A | | 17. INFORMANT
Mrs. Wm. T. Strehlau
6010 Moorehead Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X Hypertensive Cardio-vascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH
unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 4 , 1967, to Feb. 6 , 1967, that (I) (we) saw the deceased alive on Feb. 6 , 1967, and that death occurred at 4:10AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leo J. Gaver, M. D. | | 22b. DATE SIGNED
2/6/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Leo J. Gaver, M. D. | | 22d. ADDRESS
1 Mallow Hill Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2-9-67 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cem. | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. |
| 24. FUNERAL DIRECTOR
Witzke F.D.-4101 Edmondson Ave. | | 25a. REC'D BY REGISTRAR
FEB 8 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>William J. Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01967

CERTIFICATE OF DEATH

01963

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|--|--|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rowson | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21206 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | | | d. STREET ADDRESS
4304 Willshire Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Agnes Middle Madeline Last Strocker | | | | 4. DATE OF DEATH
Month February Day 7 Year 19 67 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9/8/99 | | 9. AGE (In years last birthday)
67 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Wilmer Linzey | | | | 14. MOTHER'S MAIDEN NAME
Agnes Viola Angel | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-14-9320 | | 17. INFORMANT Address
Mr Henry Strocker 4304 Wilshire Avenue 6 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis generalized
170X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the left breast
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 28 , 19 67 , to Feb. 7 , 19 67 , that (I) (we) last saw the deceased alive on Feb. 7 , 19 67 , and that death occurred at 8.55 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Charles Judge</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Charles Judge | | | | 22d. ADDRESS
7620 York Rd. Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-11-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Frankwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co. Md. | |
| 24. FUNERAL DIRECTOR
Lassala Funeral Home 1401 Belair Road | | | | ADDRESS
36 | | 25a. REC'D BY REGISTRAR
DATE FEB 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | |

01363

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RECEIVED OF DEPT. OF STATE

U.S.A.

James A. Smith

James A. Smith

215-11-120

James A. Smith

James A. Smith

James A. Smith

James A. Smith

James A. Smith

James A. Smith

James A. Smith

215-11-120

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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01966

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01964

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b 5 Months | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mill
d. STREET ADDRESS 111 Gwynnbrook Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Maryanna
First Maryanna Middle Szymborski Last Szymborski | | 4. DATE OF DEATH February 19 1967
Month February Day 19 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 27 1887 |
| 9. AGE (In years last birthday) 79 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 7 Days 9 Hours 13 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (County & State, or foreign country) Poland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME John Przyborowski | | 14. MOTHER'S MAIDEN NAME Anna UNK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --- | | 16. SOCIAL SECURITY NO. 218-10-3027B | |
| 17. INFORMANT Marie Urbanski | | Address 31 N Montford Avenue | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
4201 DUE TO (b) A.O.V.D. & AUL MYOCARDIAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) --- | | | INTERVAL BETWEEN ONSET AND DEATH --- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) --- | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. --- | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | 20f. (City or town) (County) (State) --- |
| 21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 66 , to 2/19 , 19 67 , that (I) (we) last saw the deceased alive on 2/18 , 19 67 , and that death occurred at --- M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John Shaw | | 22b. DATE SIGNED 2/20/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN SHAW | | 22d. ADDRESS 5800 EDMONDSON AVE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Feb 22, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | 23d. LOCATION (City, town or county) (State) German Hill Road Md |
| 24. FUNERAL DIRECTOR The Dippel Brothers Inc | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS 1800 E Lombard Street | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE FEB 23 1967 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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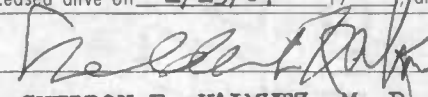

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01969

CERTIFICATE OF DEATH

01965

| | | | | | |
|--|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore Co. | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
5 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS
1816 SUTTON AVENUE | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle WALTER Last TAVENNER | | | 4. DATE OF DEATH
Month FEBRUARY Day 13 Year 1967 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 29, 1895 | 9. AGE (In years lost birthday) yrs.
71 | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WELDER | | 10b. KIND OF BUSINESS OR INDUSTRY
RAILROAD | 11. BIRTHPLACE (County & State, or foreign country)
DELAWARE, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
ALDOLE TAVENNER | | | 14. MOTHER'S MAIDEN NAME
WILLAMENA DARNELL | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | 16. SOCIAL SECURITY NO.
705 07 63 75 | 17. INFORMANT Address
CLIN. REC. VA HOSPITAL, FT HOWARD, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY INFARCTION
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) INFECTED CARDIAC ANEURYSM
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
ARTERIOSCLEROTIC HEART DISEASE, YEARS | | | | | INTERVAL BETWEEN DEATH AND REPORT
RECENT
WEEKS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (1) (this hospital) attended the deceased from 2/8/67 , 19__ to 2/13/67 , 19__, that (2) (we) last saw the deceased alive on 2/13/67 , 19__ and the death occurred at 5:10AM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED
2/13/67 | 22c. PHYSICIAN'S NAME (Type)
SHELDON E. KALMUTZ, M. D. | | |
| 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2-16-67 | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
HOWARD H. HUBBARD FUNERAL HOME | | 25a. REC'D BY REGISTRAR
FEB 16 1967 | 25b. REGISTRAR'S SIGNATURE
 | | |

01885

01885

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BALTIMORE

BALTIMORE

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VERMONT AVENUE, PORT HAWARD

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21 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01970

CERTIFICATE OF DEATH

01966

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | | c. LENGTH OF STAY IN 1b
78 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS
3 E. North Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle B. Last TAYLOR | | | | 4. DATE OF DEATH
Month FEBRUARY Day 2 Year 19 67 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 6, 1898 | |
| 9. AGE (In years last birthday) yrs.
68 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PLUMBER | | 10b. KIND OF BUSINESS OR INDUSTRY
PLUMBING SHOP | | 11. BIRTHPLACE (County & State, or foreign country)
BEREA, KENTUCKY | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 13. FATHER'S NAME
FRANK TAYLOR | | | |
| 14. MOTHER'S MAIDEN NAME
MARGARET WEAVER | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW I | | | |
| 16. SOCIAL SECURITY NO.
219 07 34 10 | | 17. INFORMANT
Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 163X METASTATIC CARCINOMA OF RIGHT KIDNEY, LIVER AND PANCREAS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } due to: CARCINOMA OF LUNG
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/16/66 , 19__, to 2/2/67 , 19__, that he (we) last saw the deceased alive on 2/2/67 , 19__, and that death occurred at 8:35AM on causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>John D. Talbert</i> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
2/2/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2/6/67 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDEN PARK NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
<i>Joseph N. Zannino</i> | | | | 25a. REC'D BY REGISTRAR
JOSEPH N. ZANNINO FUNERAL HOME
DATE FEB 8 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

100000

CERTIFICATE OF DEATH

01270

| | | | |
|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| SEX | | AGE | |
| PLACE OF BIRTH | | DATE OF BIRTH | |
| OCCUPATION | | CAUSE OF DEATH | |
| MANNER OF DEATH | | PLACE OF DEATH | |
| SIGNATURE OF REGISTRAR | | SIGNATURE OF WITNESS | |
| DATE OF REGISTRATION | | PLACE OF REGISTRATION | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEATH REGISTRATION ACT, 1953.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01977

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01967

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | c. LENGTH OF STAY IN 1b
03-1 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Box 86 Dover Road | | | | d. STREET ADDRESS
Box 86 Dover Road | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First George Middle A. Last Towsend | | | | 4. DATE OF DEATH
Month February Day 22 Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 8, 1897 | | 9. AGE (In years last birthday)
69 yrs. | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired from Baltimore Gas & Electric Co. | | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore City | | 11. BIRTHPLACE (State or foreign country)
Baltimore City | | |
| 13. FATHER'S NAME
John M. Towsend | | | | 14. MOTHER'S MAIDEN NAME
Mary E. Belt | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
212-05-6715 | | 17. INFORMANT
Mr. J. Melville Towsend Address Baltimore, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Coronary Insufficiency
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Hypertensive C-V Disease w/ Mitral Murmur; Prastatic Hypertrophy | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE D. D. Caples | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | 22. DATE SIGNED 2-23-67 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/25/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Grove | | 23d. LOCATION (City or Town) (County) (State)
Boring, Md. | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR
FEB 27 1967 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

01961

01971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
15M 4-64

01972

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01968

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Bolton</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON MD</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> | |
| c. LENGTH OF STAY IN 1b <u>4 DAYS</u> | | d. STREET ADDRESS <u>812 SHELLEY ROAD</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Joanna A. Troja</u> | | 4. DATE OF DEATH <u>Feb. 4, 1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-15-1881</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>FORT DODGE, IOWA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>DANIEL FITZPATRICK</u> | | 14. MOTHER'S MAIDEN NAME <u>CONNOLLEY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-38-8396</u> | |
| 17. INFORMANT <u>MRS HELEN A. HARTZEL (SAME)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
<u>unknown</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>67</u> , to <u>2-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>67</u> , and that death occurred at <u>3:00 P</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>David I. Miller</u> | | 22b. DATE SIGNED <u>2-4-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>David I Miller</u> | | 22d. ADDRESS <u>Garrison Rd Owings Mills, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2/7/1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Monte Maria</u> | | 23d. LOCATION (City, town or county) (State) <u>Towson, Balto Co Md</u> | |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>FEB 6 1967</u> | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01969

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RURAL - ROSEDALE | | | c. LENGTH OF STAY IN 1b
157ms | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - RoseDALE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
613 Patapsco Avenue | | | | d. STREET ADDRESS
Balto. 6 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First AVIS Middle ELIZABETH Last TROVINGER | | | | 4. DATE OF DEATH
Month February Day 15 Year 1967 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 27, 1916 | | 9. AGE (In years last birthday)
50 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Joseph S. Helms | | | | 14. MOTHER'S MAIDEN NAME
FRANCES Harwood | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
240-30-4824 | | 17. INFORMANT
Charles I. Trovinger Address 613 Patapsco Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm
330X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Rudiger Breiteneker, M.D. | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
2/15/67 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Philip E. Cuch 1211 Chesapeake Ave. | | | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01974

CERTIFICATE OF DEATH

01970

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
7mths4dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
11 North Bentalou St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Luther Middle Turner Last Turner | | | | 4. DATE OF DEATH
Month February Day 16 Year 1967 | | | |
| 5. SEX
male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 12, 1886 | 9. AGE (In years birthday) yrs.
80 | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Callie | | | | 14. MOTHER'S MAIDEN NAME
Alice | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
228-10-9408 | | 17. INFORMANT
Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe
DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Bilateral, suppurative otitis media | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour _____ a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from July 12, 1966 to Feb. 16, 1967 , that (X) (we) last saw the deceased alive on Feb. 16, 1967 , and that death occurred at 8:20 p.m., from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachsler | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2-17-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachsler, M.D. | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/19/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Goochland Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Virginia | |
| 24. FUNERAL DIRECTOR
ADOLPHUS HALSTEAD | | | | ADDRESS
1206 W North Ave | | 25a. REC'D BY REGISTRAR
FEB 20 1967 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

01970

RECORD OF DEATH

01974

01974

| | | | | | |
|----------------------|--|------------------|--|-----------------------|--|
| NAME | | DATE OF BIRTH | | DATE OF DEATH | |
| SEX | | AGE | | CAUSE OF DEATH | |
| PLACE OF BIRTH | | PLACE OF DEATH | | MANNER OF DEATH | |
| OCCUPATION | | EDUCATION | | RELIGION | |
| MARRIAGE | | CHILDREN | | BURIAL | |
| FAMILY HISTORY | | SOCIAL HISTORY | | HISTORICAL DATA | |
| PHYSICAL EXAMINATION | | LABORATORY TESTS | | PATHOLOGICAL FINDINGS | |
| TREATMENT | | PROGNOSIS | | FOLLOW-UP | |
| DISCHARGE | | REFERRAL | | ADDITIONAL COMMENTS | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01975

CERTIFICATE OF DEATH

01971

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson
c. LENGTH OF STAY IN 1b
231
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
7910 Highpoint Rd.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Ethel
First
M Middle
TYLER Last | | 4. DATE OF DEATH
Month
February
Day
10
Year
19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 15, 1895 |
| 9. AGE (In years lost birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months
7 Days
10 Hours
67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY
***** | |
| 11. BIRTHPLACE (County & State, or foreign country)
New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William J. Hopper | | 14. MOTHER'S MAIDEN NAME
Louisa James | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No ***** | | 16. SOCIAL SECURITY NO.
217-09-8196 | |
| 17. INFORMANT
Family records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
331X IMMEDIATE CAUSE (a) Cerebro-vascular accident (most probably Hemorrhage)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
DUE TO
DUE TO
DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Pulmonary Edema | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/10/ , 19 67 , to 2/10/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/10/ , 19 67 , and that death occurred at 3:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Joel V. Tolentino | | 22b. DATE SIGNED
2-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Joel V. Tolentino, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, or other disposal
Burial | 23b. DATE THEREOF
2/14/67 | 23c. NAME OF CEMETERY OR CREMATORY
Balto National Cem | 23d. LOCATION (City or Town) (County) (State)
Balto Md. |
| 24. FUNERAL DIRECTOR
C.FEVANS & SON 8802 Harford road | | 25a. REC'D BY REGISTRAR
FEB 14 1967
DATE | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

01951

15810

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01976

CERTIFICATE OF DEATH

01972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SUMMIT CONV. HOME</u> | | d. STREET ADDRESS
<u>26 NEWBURG AVE.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>GENEVIEVE L. UPMAN</u> | | 4. DATE OF DEATH <u>FEB. 27 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/16/80</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SEC.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RET.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>JOHN B. UPMAN</u> | | 14. MOTHER'S MAIDEN NAME
<u>ELLEN M. PATTERSON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>213031885</u> | |
| 17. INFORMANT
<u>PAUL KAEHLER</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>
330X DUE TO
Subarachnoid Hemorrhage
(b) DUE TO
Generalized Arteriosclerosis
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 weeks</u>
<u>4 weeks</u>
<u>10 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/31/67</u> , to <u>2/26/67</u> , that (I) <u>live</u> saw the deceased alive on <u>2/26/67</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>W E McGrath M.D.</u> | | 22b. DATE SIGNED
<u>2/28/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W E McGrath M.D.</u> | | 22d. ADDRESS
<u>1303 Frederick Rd 28</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>3/12/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>CATHEDRAL</u> | 23d. LOCATION (City or Town) (County) (State)
<u>BALTO. MD.</u> |
| 24. FUNERAL DIRECTOR
<u>E. S. MACNABB</u> | | 25a. REC'D BY REGISTRAR
<u>301 FREDERICK RD 21228</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE <u>MAR 3 1967</u> | |

VR A15 (4)
20 M 1 66

01285

05210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Approved by phone with Dr. P. P. Coffey, Medical Examiner

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---------------------------|--|--|---|-------------------------------------|--|--|--|
| 1977 | | | | | 1973 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Balto</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Pikesville</u> | | | c. LENGTH OF STAY IN 1b
<u>6 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Balto.</u> 03-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Foxleigh Nursing Home</u> | | | | | d. STREET ADDRESS
<u>3531 Milvale Rd. Balto.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Ussery, Genevieve</u> | | | 4. DATE OF DEATH
Month <u>Feb.</u> Day <u>2</u> Year <u>1967</u> | | 9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>12-24-78</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>own home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | | |
| 13. FATHER'S NAME
<u>Ward, G. D.</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>MacKew, Laura</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>213-48-6626</u> | | 17. INFORMANT Address
<u>Mr. Thomas O. Wonnell</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ASCVD-decompensated</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2 Feb</u> , 19 <u>67</u> , to <u>2 Feb</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Charles H. Williams</u> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>2 Feb 67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Charles H. Williams</u> | | | | | 22d. ADDRESS
<u>Pikesville 21208, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | 23b. DATE THEREOF
<u>Feb. 4, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Forest Ridge Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Pikesville 8, Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Norvell Funeral Home, Pikesville 8, Md.</u> | | | | | 25a. REC'D BY REGISTRAR
<u>—</u> | | 25b. REGISTRAR'S SIGNATURE
<u>—</u> | | |
| DATE
<u>FEB 6 1967</u> | | | | | Johannes, Judge | | | | |

01837

and

But. Robinson

For light turning

12322

F

W

Word. C. D.

No

ASCD. Humphreys

213-48-4838 The Street & Avenue

Mocking. Lane

Ward 1044

V. S. H.

12-24-28

Feb. 2

3231 Walnut Rd. Detroit

Post Office

2

01837

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your filer. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01978
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 12 Film G386 2/24/67 mh

01974

| | | | | | |
|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 7
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
3806 Sylvan Drive | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Md.
b. COUNTY
Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 7
d. STREET ADDRESS
3806 Sylvan Drive
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
Edith E. Vaughan
First Middle Last | | | 4. DATE OF DEATH
Feb. 15 19 67
Month Day Year | | |
| 5. SEX
F | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 15, 1888 | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
England | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Late - Harry Wadkin | | |
| 14. MOTHER'S MAIDEN NAME
Unk. | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
219-30-7312 | | |
| 16. SOCIAL SECURITY NO.
219-30-7312 | | | 17. INFORMANT
Mr. Robert E. Vaughan
108 Ligon Rd. - Ellicott City, Md. - 21043
Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)
4221 DUE TO arteriosclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Cerebral arteriosclerosis
DUE TO Diabetes Mellitus
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Inter Trochanteric Fracture Left Hip - Pinned at mass. | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Fell at home. | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 10-9 1966
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | |
| 20f. (City or town)
Clinton | | 20g. (County)
Mass | | 20h. (State)
Mass | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| Address (Street, city, town, or county)
2-16-67 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
2-18-67 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cem. | |
| 22d. LOCATION (City, town, or country)
Baltimore, Md. | | 23. FUNERAL DIRECTOR
Witzke F.D. - 4101 Edmondson Ave.
ADDRESS | | | |
| 24a. REC'D BY REGISTRAR
DATE
FEB 20 1967 | | 24b. REGISTRAR'S SIGNATURE
g Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21234 | | c. LENGTH OF STAY IN 1b
8 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
8305 Ridgely Oak Road | | d. STREET ADDRESS
8305 Ridgely Oak Road | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Bernard G. von Karstedt | | 4. DATE OF DEATH
Month Day Year
Feb. 8 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 3, 1905 |
| 9. AGE (In years lost birthday) 61 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Radio | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Bernard von Karstedt | | 14. MOTHER'S MAIDEN NAME
Alice King | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-10-8913 | |
| 17. INFORMANT
Mrs. Bernard G. von Karstedt | | 18. ADDRESS
8305 Ridgely Oak Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis
DUE TO
(b) Hypernephroma (carcinoma) kidney
DUE TO
(c) 180X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
5 yrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Malnutrition | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from 11-24-1965 , to 2-8-1967 , that (I) (we) last saw the deceased alive on Feb. 6, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
S.J. Venable, Jr., M.D. | | 22b. DATE SIGNED
2-10-67 | |
| 22c. PHYSICIAN'S NAME (Type)
S.J. Venable, Jr., M.D. | | 22d. ADDRESS
7215 York Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
2/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Pk. Baltimore Co., Md. | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
Charles E. Judge | | 25a. REC'D BY REGISTRAR
FEB 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles E. Judge | | DATE | |

01372

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01980

CERTIFICATE OF DEATH

01976

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lansdowne | | c. LENGTH OF STAY IN 1b
Lansdowne | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
154 Clyde Avenue 21227 | | d. STREET ADDRESS
154 Clyde Avenue 21227 | |
| 3. NAME OF DECEASED (Type or print)
First Elmer Middle E. Last Wain, Sr. | | 4. DATE OF DEATH
Month Feb. Day 14 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
10-13-80 |
| 9. AGE (In years last birthday)
86 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O R.R. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
George Wain | | 14. MOTHER'S MAIDEN NAME
Emity Rumney | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Gertrude E. Crivelli-154 Clyde Ave | | Address 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
451X IMMEDIATE CAUSE (a) Ruptured Abdominal Aortic Aneurysm
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1967 to Feb. 14, 1967 , that (I) (we) saw the deceased alive on Feb. 12, 1967 , and that death occurred at 11:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
C. Arthur Rossberg M.D. | | 22b. DATE SIGNED
2/15/67 | |
| 22c. PHYSICIAN'S NAME (Type)
C. Arthur Rossberg, M.D. | | 22d. ADDRESS
2436 Washington Blvd. 21230 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-17-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | | 23d. LOCATION (City or Town) (County) (State)
2930 Frederick Rd. Balto, Md. | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard-4107 Wilkens Avenue 21229 | | 25a. REC'D BY REGISTRAR
EEB 17 1967 | |
| 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | |

01370

ESTIMATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<i>Armcoast Nursing Home Regester Ave.</i> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Alma</i> Middle <i>T.</i> Last <i>Walker</i> | | | | 4. DATE OF DEATH
Month <i>February</i> Day <i>24</i> Year <i>1967</i> | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>April 4, 1890</i> | |
| 9. AGE (In years lost birthday) <i>76</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>7</i> Days <i>16</i> Hours <i>16</i> Min. | | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | | |
| 13. FATHER'S NAME
<i>Norbourn A. Thomas</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Rose Fullenkamp</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | | | 16. SOCIAL SECURITY NO.
<i>none</i> | | 17. INFORMANT
<i>Henry M. Walker 2610 Whitney Ave. Balto.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Recurrent cerebral vascular occlusion</i>
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i>
DUE TO (c) <i>8 yrs</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from <i>May 1956</i> to <i>Feb 24, 1967</i> , that (I) (we) last saw the deceased alive on <i>Feb 24, 1967</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Frederick J. Vollmer</i> | | | | 22b. DATE
<i>2-24-67</i> | | 22c. PHYSICIAN'S NAME (Type)
<i>FREDERICK J. VOLLMER</i> | |
| 22d. ADDRESS
<i>6100 YORK RD, BALTIMORE, MD.</i> | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | |
| 23b. DATE THEREOF
<i>2/27/67</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Green Mount Cemetery</i> | | 23d. LOCATION (City, town, or county) (State)
<i>Baltimore Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>John A. Moran, Inc.</i> | | | | 25a. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01982

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01978

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Owings Mills | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Reisterstown Rd. & Pleasant Hill Rd. | | | | d. STREET ADDRESS
17 Westminster Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Charles Middle E. Last Warren | | | | 4. DATE OF DEATH
Month Feb. Day 12, Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 27, 1906 | | 9. AGE (In years last birthday) yrs.
60 | 10. IF UNDER 1 YEAR
Months 03-1 Days 00 Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
James H. Warren | | | | 14. MOTHER'S MAIDEN NAME
Nora C. Townsend | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
213-03-4803 | | 17. INFORMANT
Address Mr. Charles E. Warren Jr. Sykesville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Compound fractures both legs, middle third;
DUE TO Fractured left femur; fractured cervical vertebra; fractured skull.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 min. est. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
Pedestrian crossing Reist. Rd. & struck by automobile | | | | |
| 20c. TIME OF INJURY Month, Day, Year
6:37 a.m. Feb. 12, 1967 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
Reist. Rd. | | 20f. (City or town) (County) (State)
Owings Mills Balto. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
D. D. Caples | | | M.D.
D. D. Caples, M. D. | | | 22. DATE SIGNED
2-14-67 | |
| EXAMINER'S NAME (Type)
D. D. Caples, M. D. | | | 6 Hanover Rd. Reisterstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Pleasant Hill | | 23d. LOCATION (City or Town) (County) (State)
Owings Mills, Md. | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons | | | | ADDRESS
Reisterstown, Md. | | 25a. REC'D BY REGISTRAR
DATE FEB 17 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01983

CERTIFICATE OF DEATH

01979

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. LENGTH OF STAY IN lb
<u>16 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SPRING GROVE STATE Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>RICHARD Lewis WATSON</u> | | 4. DATE OF DEATH
Month <u>FEBRUARY</u> Day <u>4</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-12-86</u> |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MANUFACTURING Co.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND, Baltimore County</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>Joseph M. Watson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Agnes E. Moran</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-10-7235</u> | |
| 17. INFORMANT
<u>JANET FADLEY - Daughter - Owings Mills, Md.</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARTION</u>
260X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO (c) <u>DIABETES MELLITUS</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>67</u> , to <u>2-4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> 19 <u>67</u> , and that death occurred at <u>940A</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Rolando Vieta</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROLANDO VIETA</u> | | 22d. ADDRESS
<u>SPRING GROVE ST. HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>2/7/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Evergreen Mem. Gardens</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Finicksburg, Carroll, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>H. J. Eckhardt</u> | | 25. REC'D BY REGISTRAR
<u>Owings Mills, Md.</u> | |
| 25a. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>FEB 7 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01383

STATE OF TEXAS

01383

Aug 10

State of Texas, County of [illegible]

I, [illegible], County Clerk of said County, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of said County.

Given under my hand and the seal of said County, at Austin, Texas, this 10th day of August, 1901.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

CERTIFICATE OF DEATH

01984

01980

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FORT HOWARD | | c. LENGTH OF STAY IN 1b
18 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS
1041 MC DONOUGH STREET | |
| 3. NAME OF DECEASED (Type or print)
First ROBERT Middle L. Last WEBSTER | | 4. DATE OF DEATH
Month FEBRUARY Day 14 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JULY 17, 1907 |
| 9. AGE (In years last birthday)
59 | | 10. IF UNDER 1 YEAR (Months) Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
WOODRUFF, SOUTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
UNKNOWN | | 14. MOTHER'S MAIDEN NAME
ANNIE MN: UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW II | | 16. SOCIAL SECURITY NO.
217 09 28 44 | |
| 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XXX (this hospital) attended the deceased from 1/27/67 , 19__, to 2/14/67 , 19__, that (X) (we) last saw the deceased alive on 2/14/67 , 19__, and that death occurred 10:00AM , from causes and on the date stated above | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
2/14/67 | |
| 22c. PHYSICIAN'S NAME (Type)
JORGE A. FABARA, M. D. | | 22d. ADDRESS
VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
2-20-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
Chas. O. Wilson | | 25a. REC'D BY REGISTRAR
DATE FEB 20 1967 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01985

01981

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER
c. LENGTH OF STAY IN 1b
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY BALTIMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS
d. STREET ADDRESS 5823 OAKLAND RD.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harold Middle R. Last White | | 4. DATE OF DEATH
Month FEBRUARY Day 7 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-16-1913 |
| 9. AGE (In years lost, birthday) 53 yrs. | | 10. IF UNDER 1 YEAR
Months 53 Days 53 Hours 53 Mm. 53 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Martin Co. | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William A. White | | 14. MOTHER'S MAIDEN NAME Louisa | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-07-5311 | |
| 17. INFORMANT ANNA WHITE | | Address 5823 OAKLAND RD. 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Coronary Occlusion
DUE TO A-S-CVD Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH

 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE M B Davis
EXAMINER'S NAME (Type) MELVIN B. DAVIS | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) 6800 MORINGTON RD. | |
| 22. DATE SIGNED 2/7/67 | | 23. DATE SIGNED 2/7/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2-11-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Howard County, Maryland | |
| 24. FUNERAL DIRECTOR HOWARD H. HUBBARD | | ADDRESS 4107 WILKENS AVE. 21229 | |
| 25a. REC'D BY REGISTRAR FEB 10 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01986

CERTIFICATE OF DEATH

01982

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 21212 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
316 Radnor Rd. | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Harry Blackwell WHITE | | 4. DATE OF DEATH
Month Day Year
February 1, 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 18, 1897 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
CONVEYER MANIPULATORS | | 10b. KIND OF BUSINESS OR INDUSTRY
Self-Employed | |
| 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
Dameary B White | | 14. MOTHER'S MAIDEN NAME
Sally Ann Bishop | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes NWI | | 16. SOCIAL SECURITY NO.
216-09-9447 | |
| 17. INFORMANT
Mrs Harry White | | Address
Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent carcinoma of right lung
DUE TO (b) Status post left pneumonectomy (1962)
DUE TO (c) Terminal bronchopneumonia. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1/14/ , 19 67 , to 2/1/ , 19 67 , that (I) (we) last saw the deceased alive on 2/1/ , 19 67 , and that death occurred at 12:30M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Fiorello G. Malit, M.D. | | 22b. DATE SIGNED
February 1, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Fiorello G. Malit, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2-4-67 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | 23d. LOCATION (City or town) (County) (State)
Baltimore Md |
| 24. FUNERAL DIRECTOR
Chas. F. Evans & Son | | 25a. REC'D BY REGISTRAR
8802 Harford Rd | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
FEB 3 1967 | |

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|---------------|--|-----------------------------|--|
| Name | | Address | |
| J. J. Johnson | | 123 Main St. | |
| City | | State | |
| New York | | New York | |
| Date | | 10/15/50 | |
| To | | J. J. Johnson | |
| From | | J. J. Johnson | |
| Subject | | J. J. Johnson | |
| Remarks | | J. J. Johnson | |
| Signature | | J. J. Johnson | |
| Date | | 10/15/50 | |
| Initials | | J. J. Johnson | |
| Address | | 123 Main St. | |
| City | | New York | |
| State | | New York | |
| Zip | | 10001 | |
| Phone | | 123-4567 | |
| Fax | | 123-4567 | |
| E-mail | | j.j.johnson@123main.com | |
| Web | | http://www.123main.com | |
| Social Media | | Facebook, Twitter, LinkedIn | |
| Other | | J. J. Johnson | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01987

CERTIFICATE OF DEATH

01983

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Josephs Hospital | | d. STREET ADDRESS
4312 Woodlea Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Theodore Middle William Last WHITE | | 4. DATE OF DEATH February 13 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 12, 19 67 AGE (In years last birthday) yrs. 35 IF UNDER 1 YEAR Months 3 Days 42 IF UNDER 24 HRS. Hours 5 Min. 42 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY - - | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Richard A. White | | 14. MOTHER'S MAIDEN NAME
June A. Edwards | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
HOSP. RECORDS | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
776X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 12 19 67 , to February 13 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 13 19 67 , and that death occurred at 2:15M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lawrence F. Misanik | | 22b. DATE SIGNED
February 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Lawrence F. Misanik, M.D. | | 22d. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
2/21/67 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home | | 25a. REC'D BY REGISTRAR
FEB 24 1967 | |
| ADDRESS
Balto., Md. 21212 | | 25b. REGISTRAR'S SIGNATURE
Charles Young | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01988

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01984

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lovson</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>ST. JOSEPH'S HOSPITAL</u> | | | | d. STREET ADDRESS
<u>5707 CHINQUAPIN PKWY</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>FRANK</u> Middle <u>L.</u> Last <u>WIELAND</u> | | | | 4. DATE OF DEATH
Month <u>FEB.</u> Day <u>21</u> Year <u>1967</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/6/94</u> | 9. AGE (In years last birthday)
<u>72</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Supv. of Transportation - Gunthers Brewery Baltimore</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>John Wieland</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Pauline Wells</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | | 16. SOCIAL SECURITY NO.
<u>215-01-9453</u> | | 17. INFORMANT
<u>Marguerite Wieland</u> Address <u>5707 Chinquapin Pkwy.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u>
DUE TO (b) <u>Coronary Insufficiency</u>
DUE TO (c) <u>and Tachycardia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hrs</u>
<u>6 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D. | | | | 22. DATE SIGNED
<u>2/21/67</u> | | | |
| EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u> | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/25/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Olive</u> | | 23d. LOCATION (City or Town) _____ (County) _____ (State) <u>Balto Md</u> | |
| 24. FUNERAL DIRECTOR
<u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR
<u>FEB 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

42810

28810

Case 12345

Case 12345

2-12-1944

Frank J. ...

11/1/44

Ref. Copy of transcription - and original - ...

John ...

10-2-1944 ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|------------------|---------------------------------------|---|---|------------------|---|--|---|---|---|-------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 01989 | | | | | | 01985 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY Baltimore, MARYLAND | | | | | | a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fork | | | | c. LENGTH OF STAY IN 1b
Life | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fork, Maryland 21051 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Box 498 Stoney Batter Road | | | | | | d. STREET ADDRESS
Box 498 Stoney Batter Rd. | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| Herman Henry Willig | | | | | | February 23 | | | 1967 | | |
| 5. SEX | 6. COLOR OR RACE | 7. MARRIED | <input checked="" type="checkbox"/> NEVER MARRIED | <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours |
| M | W | WIDOWED <input type="checkbox"/> | DIVORCED <input type="checkbox"/> | | 5/30/1886 | 80 yrs. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Florist | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Business | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore Co. Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
Martin Willig | | | | | | 14. MOTHER'S MAIDEN NAME
Margaret Knox | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mr John H. Willig Box 498 Stoney Batter Rd | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary Thrombosis
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) generalized arteriosclerosis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
immediate | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/13, 1967 , to present , 19 67 , that (I) (we) last saw the deceased alive on Feb. 7 1967 , and that death occurred at 11:15 AM , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Phyllis K. Pullen | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
2/23/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Phyllis K. Pullen | | | | | | 22d. ADDRESS
Box 381 Route 1 Kingsville, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-25-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Fork Meth. Ch. Cemetery | | | 23d. LOCATION (City, town or county) (State)
Fork, Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Lassahn Funeral Home 7401 Belair Road | | | | | | 25a. REC'D BY REGISTRAR
36 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |
| DATE FEB 27 1967 | | | | | | | | | | | |

01882

01882

Box 195 Honey cutter Road
Box 195 Honey cutter Road
Box 195 Honey cutter Road

Clinton Low business
Clinton Low business
Clinton Low business

Clinton Low business

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

Mr John A. Miller of 195 Honey cutter Rd

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 01990 | | | | | 01986 | | | | | | | | | |
| Item 9 Film 6385 2/8/67 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BMC Hospital
c. LENGTH OF STAY IN 1b 48 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE Medical Center | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY BALTIMORE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TIMONIUM, Md. 21093
d. STREET ADDRESS 241 EAST TIMONIUM ROAD
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Marie First ANNA Middle WILMOT Last | | | | | 4. DATE OF DEATH 2 - 1 - 1967 Month 2 Day 1 Year 1967 | | | | | | | | | |
| 5. SEX Female | | | | | 6. COLOR OR RACE CAU | | | | | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH 12-29-86 | | | | | | | | | |
| 9. AGE (In years last birthday) 80 yrs. | | | | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 35 Min. P.M. | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Philadelphia, PENN | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13. FATHER'S NAME George Richard Zimmerman | | | | | 14. MOTHER'S MAIDEN NAME HARRIET LOWERY | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | 16. SOCIAL SECURITY NO. 24-30-0835-11 | | | | | | | | | |
| 17. INFORMANT Address | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Respiratory failure
200.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia
DUE TO (c) lymphosarcoma | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 5:35 a.m. 1967 | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | 22b. DATE SIGNED 2-1-67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) [Signature] | | | | | 22d. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE THEREOF SAT 2/4/67 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Great Valley Presby Cem. | | | | | 23d. LOCATION (City, town or county) (State) Malvern R.D. Chester, PA. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wm. Cook Brooks Inc. 57 Paul I Preston | | | | | 25a. REC'D BY REGISTRAR FEB 6 1967 | | | | | | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |

01300

01300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01991

CERTIFICATE OF DEATH

01987

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| Baltimore | | Baltimore 21212 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
St. Joseph Hospital | | d. STREET ADDRESS
116 Dumbarton Rd. Apt. D | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Edward Nicholas Witler | | 4. DATE OF DEATH
Month Day Year
Feb. 27 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-16-99 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed | | 10b. KIND OF BUSINESS OR INDUSTRY
Insurance Broker | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Edward Nicholas Witler | | 14. MOTHER'S MAIDEN NAME
Emma Williams | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
216 01 0641 A | |
| 17. INFORMANT
M. Agnes Witler | | Address
116 Dumbarton Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease -myocardial infarction
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Carcinoma of colon | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 25 1967 to Feb. 27 1967 , that (I) (we) last saw the deceased alive on Feb. 27 1967 , and that death occurred at 5:35 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Melencio Ventura | | 22b. DATE SIGNED
Feb. 27, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Melencio Ventura M.D. | | 22d. ADDRESS
7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Mar. 2, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Charles Judge | | 25. REC'D BY REGISTRAR
MAR 2 1967 | |
| 25. REGISTRAR'S SIGNATURE
Charles Judge | | 4611 Park Heights Ave. | |

52010

10210

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6 1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01992

01988

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparrows Point | | c. LENGTH OF STAY IN 1b
Hours ?? | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Plant Dispensary, Beth Steel | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River | |
| 3. NAME OF DECEASED (Type or print)
First Emory Middle Lindley Last Wolfe | | 4. DATE OF DEATH
Month 2 Day 7 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-6-07 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel Making | |
| 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Emory Wolfe | | 14. MOTHER'S MAIDEN NAME
Anna Carter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
178-07-3185 | |
| 17. INFORMANT (Wife)
Virginia Wolfe, 37 Stabilizer Dr. Middle River | | Address Md. 21220 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary-Arterio-scleriotic cardio vascular disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201
(c) disease. | | INTERVAL BETWEEN ONSET AND DEATH
Stat | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> N | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
O | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
at home | | 20f. (City or town) (County) (State)
Middle River | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
M B Davis | | 22. DATE SIGNED
2-7-67 | |
| EXAMINER'S NAME (Type)
Melvin B. Davis, M.D. | | 6800 Mornington Rd. Dundalk, Md. 21222 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2/11/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Moreland Mem. Park Cem. | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25a. REC'D BY REGISTRAR
FEB 9 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Item #11 infor taken from birth cert. **CERTIFICATE OF DEATH**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> <i>MARYLAND</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>MARYLAND</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>WHITEHALL, MD.</i> | |
| c. LENGTH OF STAY IN 1b <i>2 HRS.</i> | | d. STREET ADDRESS <i>Mc COMAS ROAD</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>GREATER Baltimore Medical Center</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Baby</i> | | 4. DATE OF DEATH <i>Feb 17 1967</i> | |
| 5. SEX <i>MALE</i> | | 6. COLOR OR RACE <i>WHITE</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>2-17-67</i> | |
| 9. AGE (In years last birthday) <i>2</i> yrs. | | 10. IF UNDER 1 YEAR: Months <i>2</i> Days <i>26</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Towson, Balto. Co.</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Joseph L. Woodward</i> | | 14. MOTHER'S MAIDEN NAME <i>Barbara Gehston</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Prematurity</i>
<i>776X</i> DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <i>121.0</i>
<i>2 hrs</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2-17</i> , 19 <i>67</i> , to <i>2-17</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2-17</i> , 19 <i>67</i> , and that death occurred at <i>4:20</i> PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>C. Simmons</i> | | 22b. DATE SIGNED <i>2-17-67</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>C. Simmons</i> | | 22d. ADDRESS <i>Greater Balto. Med. Center</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i> | | 23b. DATE THEREOF <i>2/20/67</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>G.B.M.C.</i> | | 23d. LOCATION (City, town or county) (State) <i>Towson, Md.</i> | |
| 25a. REC'D BY REGISTRAR <i>John E. Adams, M.D.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |
| 25c. DATE <i>MAR 23 1967</i> | | | |

03530

03530

Mr. James Wood
Columbia, Md.
Maryland

James J. Woodman

John E. Adams, M.D. 6/10/67
G. B. M.C.
C. Timmons

Greenfield, N.H. Under
Town + Md.
x

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01994

CERTIFICATE OF DEATH

01989

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CATONSVILLE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
CATON RIDGE NURSING HOME | | d. STREET ADDRESS
4376 PARKTON ST. | |
| 3. NAME OF DECEASED
(Type or print) ROBERTA ZIEGLER
First Middle Last | | 4. DATE OF DEATH
Month Day Year
2 - 12 - 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/18/1890 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
ROBERT PORTER | | 14. MOTHER'S MAIDEN NAME
ANNA DANIELS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT
CLIFTON E. ZIEGLER | | Address
416 STRATFORD RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ② Probably Aspiration
DUE TO
(c) ③ Arteriosclerotic Dementia (C.B.S.) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus - Hiatus Hernia - Old Fr. RT Femoral Neck | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5-3- , 1963, to 2-12- , 1967, that (I) (we) last saw the deceased alive on 2-12-1967 , and that death occurred at 12 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Cesar Valle Caverio | | 22b. DATE SIGNED
2-12-67 | |
| 22c. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO | | 22d. ADDRESS
8629 LIBERTY RD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
2/15/1967 | 23c. NAME OF CEMETERY OR CREMATORY
NEW CATHEDRAL CEM. | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MARYLAND |
| 24. FUNERAL DIRECTOR
WEBER FUNERAL HOME | | 25a. REC'D BY REGISTRAR
5311 EDMONDS WAY | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

42910

4010

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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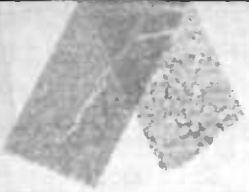
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01990

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|--|--|---|--------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore Highlands | | | | c. LENGTH OF STAY IN 1b
13-1 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2813 Oak Grove Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle ZOUCK Last ZOUCK | | | | 4. DATE OF DEATH
Month February Day 8 Year 19 67 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
8-31-1907 | | 9. AGE (In years lost birthday)
59 yrs. | 10. IF UNDER 1 YEAR
Months 59 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Franklin H. Zouck | | | | 14. MOTHER'S MAIDEN NAME
Elizabeth Gardner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
139-03-2080 | | 17. INFORMANT
Mr. Howard L. Houck, Huntington, West Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X Massive Cerebellar Hemorrhage
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Rudiger Breiteneker, M.D.
EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
Address (Street, city, town, or county) | | | |
| 22. DATE SIGNED
2/9/67 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
2-11-1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Avenue | | | | ADDRESS
21229 | | 25a. REC'D BY REGISTRAR
FEB 14 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |



61332

TO THE HONORABLE
MEMBER OF CONGRESS
FROM THE
COUNTY OF
STATE OF
DATE
SUBJECT

[Handwritten signature]

Very respectfully,
[Signature]
[Name]
[Address]
[City, State, Zip]